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SOCIAL INTERACTION OF THE ORTHOPEDICALLY DISABLED:

As Viewed By The Disabled

By

Caroline Colton Francis

B.A., University of Montana, 1969

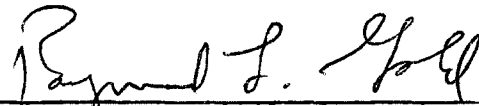
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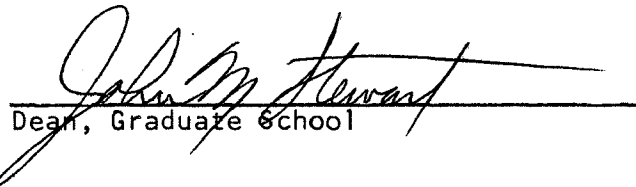
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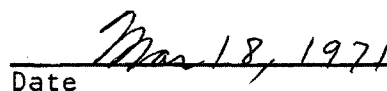
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CHAPTER I

INTRODUCTION

Since medieval times when deformity was associated in the minds of men with the Devil, Malignity, Sin, and Evil Spirits, man has feared the unknown and unexplained. This fear caused the Greeks to physically brand impaired individuals in ancient times, and more recently we have mentally branded our physically handicapped by stereotyping them as subhuman individuals. Man has tended to make a fetish of beauty so that the concepts of "body-whole" and "body-beautiful" have become the ideal. The physically handicapped deviate from this norm. As a result of their limited physical equipment, the physically disabled have been "stigmatized" and set apart.

Suddenly and without warning the handicapped individual is a stranger in his once familiar and taken-for-granted society. Personal relations previously taken for granted suddenly become problematic due to the fact that a person " . . . leaves one social group or culture without making a satisfactory adjustment to another and finds himself on the margin of each but a member of neither."¹ The physically handicapped person must continually face the problem of how to behave due to the fact that he is no longer accepted as an equal by the society of nonhandicapped persons.

It is the coping behavior of physically handicapped persons that was the subject of this research. As Erving Goffman states:

¹ Everett V. Stonequist, The Marginal Man (New York, 1961), pp. 2-3.

"Because change from stigmatized status to normal status is presumably in a desired direction, it is understandable that the change, when it comes, can be sustained psychologically by the individual. But it is very difficult to understand how individuals who sustain a sudden transformation of their life from that of a normal to that of a stigmatized person can survive the change psychologically; yet very often they do. That both types of transformation can be sustained--but especially the latter type--suggests that standard capacities and training equip us to handle both possibilities."²

The present report is an ethnographic study of the physically handicapped conducted in order to identify and describe some of the modal patterns of face-to-face interaction between disabled and nondisabled persons which assist the handicapped individual in adjusting to his new social position.

²Erving Goffman, Stigma (New Jersey, 1963), p. 132.

CHAPTER 2

LITERATURE REVIEW

What is stigma? Who are some of the people affected by it? Why are some affected and not others? What are the consequences of stigmatization? These are several of the questions I have discussed from recent literature in order to understand more fully the reasons why the physically handicapped feel the need to adjust their social behavior after becoming disabled.

Henry Kessler points out that the physically disabled all have problems to meet as they attempt to adjust their limited physical equipment to the demands of their social environment. The worst of these is the attitude he calls "psychosocial prejudice." It is "an individual and collective reaction of hostility toward the crippled, the deformed, and the disabled, who are condemned as unproductive and useless burdens."³ Instead of labeling this negative attitude prejudice, Erving Goffman calls it "stigma." Stigma is an undesired differentness that repels normal individuals. "An individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim his other attributes have on us."⁴ "We believe that a person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly,

³Henry H. Kessler, Rehabilitation of the Physically Handicapped (New York, 1947), pp. 18-19.

⁴Erving Goffman, Stigma (New Jersey, 1963), p. 3.

reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents. . . ."⁵

The concept of stigma is applicable to numerous other groups in addition to the physically handicapped. Perhaps the strongest example of an ideology to explain inferiority can be found in the Hindu caste system of India. The caste system involves precise rules of interaction, interdependence, hierarchy, and allocation of power and privilege.⁶ Its stratification system is maintained through religious dogma with each graded rank representing a step closer to purity and unity with God. The concept of untouchability or the power to defile certain classes of men with whom one may come into contact is built into the system.⁷ Expressions of common culture are inhibited through rigid sanctions enforcing caste-specific behavior and attributes. Each caste has a particular graded rank "defined by tradition and public opinion, and each one maintains it at all costs, or strives to self [wishes for self-improvement]."⁸ Discrimination in this case has become institutionalized.

Minorities of all types are also subject to differential treatment due to stigmatization. Richard Schermerhorn defines minority with this concept. He states, "minorities are sub-groups within a culture which are distinguishable from the dominant groups by reasons of differences in physiology, language, customs, or culture patterns (including any combination of these factors). Such sub-groups are regarded as inherently different and not belonging to the dominant groups; for this reason they are

⁵ Ibid., p. 5.

⁶ G. D. Berreman, "Caste As A Social Process," Southwestern Journal of Anthropology 23 (Winter, 1967), p. 355.

⁷ Oliver Cromwell Cox, Caste, Class and Race (New York, 1959), p. 33.

⁸ Ibid., p. 11.

consciously or unconsciously excluded from full participation in the life of the culture."⁹ American history is abundant with examples of stigmatized minority groups. The concept of nativism lies behind much of this behavior. Nativism is "an intense opposition to an internal minority on the grounds of its foreign connections."¹⁰ It is a zeal to destroy the enemies of American culture. Nativists throughout history identified cultural differences and suspecting a failure to assimilate this differentness, they developed a fear of disloyalty and of destruction of their cultural values. Discrimination by means of oppression often resulted. Catholics were feared because of their loyalty to the Pope. The McCarthy Era with its fear of Communist take-over led to increased suspiciousness and restraints. The following quote from the Salem witch trials illustrates their fear of alteration: "Satan Rages Principally amongst the Visible Subjects of Christ's Kingdom and makes use (at least in appearance) of some of them to afflict others; that Christ's Kingdom may be divided against it self, and so be weakened [sic]."¹¹

According to Symbolic Interaction theory, "human beings act toward things on the basis of the meanings that things have for them, . . . (and) the meanings of such things is derived from, or arises out of, the social interaction that one has with one's fellows."¹² Alfred Adler states that physical defects, congenital or acquired, may raise feelings of inferiority

⁹Richard Schermerhorn, These Our People (Boston, 1949), p. 5.

¹⁰John Higham, Strangers In The Land: Patterns of American Nativism 1880 - 1925 (New Jersey, 1955), p. 4.

¹¹George Lincoln Burr (ed.), Narratives of the Witchcraft Cases (New York, 1914), p. 163.

¹²Herbert Blumer, Symbolic Interactionism (New Jersey, 1969), p. 2.

or inadequacy within the individual which in turn create various compensatory mechanisms in behavior.¹³ Goffman says that learning experiences tend to be similar for persons with a particular stigma, and these experiences are both caused and affected by commitment to a similar sequence of personal adjustments.¹⁴ Because the behavior of an individual is guided by social values and norms, a pattern arises out of the individual's involvement.¹⁵ Marvin B. Sussman points out in his article "Dependent Disabled and Dependent Poor: Similarity of Conceptual Issues and Research Needs" that one's behavior is altered, not primarily because of the impairment per se, but because one "experiences" disability by the social response to it.¹⁶ Differentness and disability are often equated. Beatrice Wright explains why when she states that if a person has a need to safeguard his values, he will either insist that the person he considers different is suffering or devalue the person because he ought to suffer and does not. The "normal" individual wants the person to suffer as a sign that the values denied the unfortunate are worthy, important, and good.¹⁷ Disability is a socially structured phenomenon again not limited only to those with physical impairments. Migrant farm workers, emigrants, and welfare

¹³Theodor J. Litman, "Self-Conception and Physical Rehabilitation," In Rose, Arnold M., Human Behavior and Social Process: An Interactionist Approach (Boston, 1962), p. 557.

¹⁴Erving Goffman, Stigma (New Jersey, 1963), p. 32.

¹⁵Erving Goffman, Behavior In Public Places (New York, 1963), p. 193.

¹⁶Marvin B. Sussman, "Dependent Disabled and Dependent Poor: Similarity of Conceptual Issues and Research Needs," Social Service Review 43 (December, 1969), p. 385.

¹⁷*Ibid.*, p. 386.

recipients are all minorities which suffer from economic and cultural impairments which set them apart as different and therefore disabled.

According to Sidney Jordan,¹⁸ the common trait that the disadvantaged group members possess is the means by which they are identified by the nondisadvantaged group. Social reactions experienced by the disadvantaged group members stem from two factors. First is the incapacity of the nondisabled to understand the consequences and limitations of the disability. Second is the fact that the stigmatizing characteristic of the disability is believed to pertain to the entire personality of the individual and his behavior. He is thus stereotyped from one discernible fact. Behaviors designed to help the disadvantaged (the stigmatized) are positively sanctioned, however, culturally prescribed sanctions tend to preclude behaviors that would reduce tension and enable the disadvantaged to fully participate in nondisadvantaged society.

The result of stigmatization is exclusion or only limited inclusion in a social group. Aspiration for membership in the nondisabled group, however, is strong. Marginality¹⁹ is thus created. Monica Baldwin describes her plight upon leaving the convent after twenty-eight years as a Catholic nun. Her story reveals the stigmatization, unpreparedness, and insecurity one experiences in this marginal situation:

"As I crossed it (threshold), two thoughts occurred to me. One was that the door which at that instant was being locked behind me was not a door but a guillotine. And it had just chopped off from me, utterly and irrevocably, every single thing which, for twenty-eight years, had made up my life. Henceforth I was a being without a background."²⁰

¹⁸ Sidney Jordan, "The Disadvantaged Groups: A Concept Applicable to the Handicapped," Journal of Psychology 55 (1963), pp. 313-22.

¹⁹ Everett V. Stonequist, The Marginal Man (New York, 1961), pp. 2-3.

²⁰ Monica Baldwin, I Leap Over The Wall (New York, 1950), pp. 6-7.

How similar this account sounds when we think of the emigrant cut off from his native land, the Mexican migrant farm workers on a Northern farm, and the physically handicapped in a nonhandicapped society.

Past research in the area of rehabilitation has stressed the relationship between sociocultural factors and rehabilitation. Theodor Litman has studied the relationship between such factors as individual pre-traumatic experiences, family constellation, age, degree of family solidarity, etc. and rehabilitation response.²¹ From these studies we know that these factors are related to rehabilitation, but nothing is mentioned of how the physically handicapped individual interacts from day to day with his nondisabled contemporaries.

There is a need according to Goffman to identify the countless patterns and natural sequences of behavior occurring whenever people come together. By piecing together the patterns of involvement of each participant, he says we can determine a structure of involvement for the situation. An objective of the study of face-to-face interaction should be to describe the modal patterns of interaction.²² Because of similar learning experiences, similar compensatory mechanisms should be found in the face-to-face interaction of people with similar disabilities as well as among the disabled in general. The disabled in general are excluded from nondisabled society; however, the particular areas of nonparticipation differ. For instance, the degree of institutionalization of the stigma such

²¹Theodor J. Litman, "Self-Conception and Physical Rehabilitation" In Rose, Arnold M., Human Behavior and Social Process: An Interactionist Approach (Boston, 1962), pp. 550-74; and "The Influence of Self-Conception and Life Orientation Factors in the Rehabilitation of the Orthopedically Disabled," Journal of Health and Human Behavior 11, (1962), pp. 249-57.

²²Erving Goffman, Interaction Ritual (New York, 1967), p. 2.

as the stringent restrictions of the Hindu caste system versus the limited restrictions on the emigrant varies the amount of compensatory behavior necessary for interaction. However, caste members behave similarly when interacting with those of another caste, and emigrants with those of the dominant cultural group. Thus the physically disabled with similar disabilities ought to have similar modal patterns (most frequent patterns) of compensatory behavior which can be pieced together by the researcher to reveal a structure of face-to-face interaction of the physically handicapped with the nonhandicapped.

CHAPTER 3

METHODOLOGY

This study was conducted following the guidelines for inductive research outlined by Glaser and Strauss in The Discovery of Grounded Theory: Strategies for Qualitative Research.²³ In this chapter the constant comparative method will be discussed as well as a description of my sample that was utilized and the techniques used for obtaining my data.

The Constant Comparative Method for Qualitative Analysis

The underlying operation of this method of analysis is the concurrent collection, coding, and analysis of data called Theoretical Sampling. By these procedures the researcher decides what data to collect next and where it is to be found in order to develop a theory as it emerges from the data. One begins with a partial framework; from there the theory emerges from empirically grounded data. The partial framework serves as a starting point for the inquiry and consists of a question or problem which the researcher wishes to solve.

Using this problem as a guide, the researcher collects some initial data. He then codes the responses into as many categories as possible. Later responses are then compared with the initial ones for similarities or differences that might put them into one category or another.

"The analyst starts by coding each incident in his data into as many categories of analysis as possible, as categories emerge or as data emerge that fit an existing category."²⁴

²³Barney G. Glaser and Anselm L. Strauss, The Discovery of Grounded Theory: Strategies for Qualitative Research, (Illinois, 1967), Chapter V., pp. 101-15.

²⁴Ibid., p. 105.

The defining rule of the constant comparative method is "while coding an incident for a category, compare it with the previous incidents in the same and different groups coded in the same category."²⁵ Properties of the various categories thus begin to emerge through the process of comparison.

"(A)s coding continues, the constant comparative units change from comparison of incident with incident to comparison of incident with properties of the category that resulted from initial comparisons of incidents."²⁶

Thus the characteristics of each category emerge through a processual scheme of hypotheses about behavior occurring rather than from the testing of a single hypothesis.

"By joint collection and analysis, the sociologist is tapping to the fullest extent the in vivo patterns of integration in the data itself; questions guide the collection of data to fill in gaps and to extend the theory--and this also is an integrative strategy."²⁷

Herbert Blumer in his book Symbolic Interactionism supports the relevance of a processual scheme of hypotheses when he states:

"Obviously, the data are set by the problem--which indicates the importance of being sure of the satisfactory character of the problem. Even though set by the problem, the data need to be constantly examined to see if they require a revision or rejection of the problem."²⁸

Hypotheses guide the researcher in his search for data, and the data in turn should guide the researcher towards the revision of his hypotheses

²⁵ Ibid., p. 106.

²⁶ Ibid., p. 108.

²⁷ Ibid., p. 109.

²⁸ Herbert Blumer, Symbolic Interactionism (New Jersey, 1969), p. 25.

and eventually to a theory of behavior. Theories in the case of the constant comparative method are formed as the researcher discovers underlying uniformities between categories. However in the case of this study, I will stop at the point of identifying and characterizing the modal patterns (categories) of face-to-face interaction between the handicapped and the nonhandicapped.

Selection of Sample

Following Erving Goffman's statement that similar disability leads to similar patterns of behavior due to similar learning experiences,²⁹ I decided to study the orthopedically handicapped. I patterned my choice of disability after Theodor J. Litman's studies of the orthopedically disabled.³⁰ Only those disabilities which had a fairly sudden onset brought on by either disease or accident and which resulted in a loss or impaired use of the extremities were utilized. "In each case, the physical presence of the paralyzed member(s) were retained while use and function were inhibited. Since the body remains physically intact and the effects of disfigurement and distortion upon others are minimized, there is maximum opportunity for the individual's own evaluation of what has happened to him in relation to other"³¹ I wanted individuals who had been

²⁹ Erving Goffman, Stigma (New Jersey, 1963), p. 32.

³⁰ Theodor J. Litman, "Self-Conception and Physical Rehabilitation" In Rose, Arnold M., Human Behavior and Social Processes: An Interactionist Approach (Boston, 1962), pp. 550-74; and "The Influence of Self-Conception and Life Orientation Factors in the Rehabilitation of Orthopedically Disabled," Journal of Health and Human Behavior III, (1962), p. 558.

³¹ Theodor J. Litman, "Self-Conception and Physical Rehabilitation" In Rose, Arnold M., Human Behavior and Social Process: An Interactionist Approach (Boston, 1962), p. 558.

disabled after adolescence because I felt that they would have more insight into the differences between their previous interaction as a "normal" and the interaction they experience as a handicapped person. I chose the age span between twenty and thirty years old because I felt that these individuals would be more apt to question their new social status and less apt to passively accept their situation as a consequence of aging.

I contacted Phyllis Bagely, chief therapist at the Missoula Crippled Children and Adult Rehabilitation Center, Missoula, Montana. Because of a shortage of orthopedically disabled belonging to this age group in the Missoula area, it was decided to expand the upper age limit to fifty years old. This allowed for the addition of two more individuals to the study. From Miss Bagely I obtained a list of eight orthopedically handicapped persons. Due to the timing of the study, two informants had to be eliminated because they had left Missoula for the summer. Thus six individuals (one stroke, one swimming accident, and four automobile accident victims) constituted my sample.

Data Collection Procedures

Contact with the patients was made first by Miss Bagely who asked the people to participate and gave her sanction to the study. This was done in order to assure the patients of the legitimacy of my need for personal information. First interviews were conducted in late May and were followed up with one or two interviews in July and August. (See Appendixes A and B for representative interviews.) I wanted to know how these individuals felt their interaction differed from their conception of the "normal" to "normal" situation. How did they cope with their incapacibilities from day to day? What future did they see for themselves? How did "normals" react.

to their incapacities? Questions like these I felt held the key to the behavior patterns which were necessary for these individuals to cope with the stigma of public opinion against them.

During the first interview with each informant, I asked each person to describe his accident or illness in order to orient myself to their circumstances and to relax the informant. I then asked them how their interaction differed from when they were "normal." This question when asked in this manner was fruitless. All the patients claimed no difference in comparison to when they were well. It was when I asked them to describe their capabilities and their feelings about them that they began to relate personal incidents where the difference in interaction became apparent.

Several problems were faced during data collection. The first was the problem of relaxing the respondent. The patients were aware of the personal quality of my questions. I had to make them feel at ease and willing to reflect on painful areas of recollection. During the first interview I accomplished this by asking the respondents to relate their stories of their accident or illness. This forced them to recall unpleasant incidents; however, it gave us a common ground of understanding. In subsequent interviews, it became increasingly difficult in some cases to keep the relaxed atmosphere of openness. I found that by interjecting comments of my own tendencies and those of fictitious people I could create a feeling of empathy with the informant, and he was more willing to reveal his personal thoughts and feelings.

The second problem was in making the familiar strange. When asked to tell me about their routines for instance, they responded with short, superficial descriptions. I had to force the informant to look at his response closer by asking questions such as: How do you feel about it?

How would you like it changed? What makes it worth while? How do you create excitement in your life? Do you feel like an automaton or like a person? Is your routine challenging in some respects? Questions such as these made the informants look at their routine in another framework and forced them to question their behavior in order to understand why they behaved in such a manner.

I coded the responses from my first interview into as many categories of social interaction as I was able to recognize. After this, the incidents in each subsequent interview were compared with those in the original categories. When behaviors were similar or duplicated, those in the original categories, these behaviors were noted in the category. When the new behaviors were revealed, they became additional categories. Comparisons among the similar incidents in each category yielded a list of properties or characteristics which made them similar. These properties then became the means by which the category was defined. When new categories emerged, I modified my questioning in subsequent interviews to clarify the characteristics of this category. Thus my collection and analysis of data occurred concurrently.

After my individual interviews were completed, I attempted a group interview with three of the informants. One of the informants became ill and could not participate; however, I feel that a good deal of clarification was accomplished by bringing two of my informants together. These two males had been friends for at least fifteen years. They grew up together and were close friends before either was injured. They had remained friends after one broke his neck in a swimming accident and after the other was hurt when he was thrown from a car in an automobile accident. Herbert Blumer says:

"One should sedulously seek participants in the sphere of life who are acute observers and who are well informed A small number of individuals, brought together as a discussion and resource group, is more valuable many times over than any representative sample. Such a group, discussing collectively their sphere of life and probing into it as they meet one another's disagreements, will do more to lift the veils covering the sphere of life than any other device I know of."³²

These two males related their stories in more detail, I feel, in response to hearing each other's views. Also, one was able to add details of how he felt as a normal when his friend was disabled. He helped to explain his own actions then and those of other friends toward the handicapped.

In addition to interviewing the respondents, I talked with their physical therapist, Miss Bagely, wives, a mother, and an employer. I also talked informally with several individuals who had no contact with these disabled to see if the views of the six handicapped people on face-to-face interaction with the nonhandicapped were the same as those of the latter.

Finally, I spent some time observing the six individuals during therapy sessions, teaching classes, and at home. These observations served to reinforce my findings on actual behavior and pointed out new areas worth investigating during interview sessions such as the avoidance of revealing one's personal feelings to strangers.

³²Herbert Blumer, Symbolic Interactionism (New Jersey, 1969), p. 41.

CHAPTER 4

ANALYSIS OF DATA

The research objective of this study was to identify and describe the modal patterns of face-to-face interaction between the orthopedically handicapped and the nonhandicapped persons, and to see if indeed a similar disability did lead to similar patterns of behavior. I have concentrated on the area of the handicapped in hopes of seeing how these individuals have coped with the taken-for-granted world which they can no longer take for granted because it has become strange. Erving Goffman states that "exotic differentness is . . . useful . . . as a means of making one aware of assumptions ordinarily so fully satisfied as to escape one's awareness."³³ I have attempted to illustrate the relevance of my findings by comparing them with similar findings illustrated by Goffman in his book Stigma whenever possible. Goffman has compiled extensive personal accounts of how stigmatized individuals feel about themselves and their relationship with "normals." His natural accounts stress the need of the stigmatized to adjust to a world which refuses to accept them. Because of the emphasis on natural accounts by both Goffman and myself, I hope to illustrate their comparability. In order to illustrate the fact that stigmatization is not unique to the physically handicapped, I have included a brief discussion from recent literature of the effect stigmatization has on the behavior of the welfare client. Such discussions help broaden our understanding of society in general. Finally, a brief discussion of Symbolic Interaction as it helps to clarify my results is included.

³³ Erving Goffman, Stigma (New Jersey, 1963), pp. 126-27.

MODAL PATTERNS OF THE HANDICAPPED

Independence Behavior

"If you wanted to hang around with somebody, it was because you didn't feel like being by yourself, but you could do anything you wanted to by yourself if you wanted to which I can't do now."

It was this comment on what life was like before becoming disabled that started me thinking in terms of independence. Further elaboration came from other informants while discussing the differences in how people treated them before and presently.

"Oh, they all treat me with more caution and want to help me more and all which I don't need. I'm very independent and always have been which is good I guess."

After I noticed the notion of dependence being mentioned by several persons, I began asking direct questions to understand the category more fully. "How do you rationalize this dependence to yourself? You said that with the kids you made it a game whereby you were doing them a favor by letting them help you. Is this the way you rationalize it?" "How do you feel about having other people help you with these things all the time?" Inquiries into dependence yielded further questions; for instance, "does dependence yield a sensitivity to what others think of you?"

"I have a function in society. If I don't, I'm dead. Man is a social animal. I'm more social than most. What people think of me is very important possibly because I'm so dependent on them. I don't know. I have to look good in my eyes and I think the way to do this is to look good in someone else's eyes."

As behavior relating to independence was uncovered it was added to the category until the following characterization became apparent. In our

society adulthood and independence have been strongly associated. With the achievement of adulthood comes the ability to earn one's own living and the expectancy that one should leave the parental home and strike out for oneself.

"I have to get away from home and turn my folks loose. They have to live some part of their life before they are too old to. You don't realize how much I have held us down . . ."

Dependence is essentially a child-like state. It is a state of accepting charity with no reciprocation.

"To be able to buy something, to build something if you want, to go someplace. The idea that I can finance it myself. It won't happen because of charity. If anything else, I will be able to pay someone else to do it. This is what drives me."

The ability to reciprocate appears to be a major part of independence in the handicapped individual's eyes. Reciprocation gives one self-respect because it allows one to feel equal when one is able to give as much as one takes.

Independence is symbolized by the ability to work.

Question: "What spurs you on?"

Answer: "Just getting well so I can get back to work, I think, take care of my own house and do all these things myself. I don't like to have anybody wait on me and do my work for me. I've got to get back to work."

"I don't give a damn about anybody else. As soon as I can be a provider again, the happier I'll be."

Independence is also seen as the essence of "normality." The handicapped visualize the nonhandicapped as being able to do what they want when they want. This is one of the reasons why the disabled person

feels in but not of our society. He feels present physically, but until he is allowed to contribute usefully to our society in the manner he wishes, he is not really a member. The handicapped feel oppressed by their dependence. One informant stated he thought he knew how it felt to be a Negro because he was dependent on the larger society for his image of usefulness.

"I think I know what a Negro feels like when he is truly discriminated against. I think I do. It's rather frustrating to go downtown to mail a letter and the building is there, but not to be able to go inside."

"It's like having a huge corrugated metal fence that you can see through. You can't get over it or around it, but you can sit on the outside and watch what is going on inside. Every once in awhile somebody comes over and pokes a little cotton candy through the fence."

Question: "What would be the cotton candy?"

Answer: "Just being able to have a job. The biggest thing the physically handicapped want is independence. I want to be able to do things by myself for myself."

Finally for the male individuals in my study, independence symbolizes manliness. There is a succession of symbols: work symbolizing independence, independence symbolizing usefulness, usefulness symbolizing manliness and success.

"For me to be any kind of a man in my own eyes, I have to be as independent as I can."

Because independence is significant to the orthopedically disabled, their behavior patterns take it into account. There appear to be essentially four methods of coping with the desire for independence. The first method is simply realizing that one needs help and that one just has to have it. The individual finds himself in a situation where he is unable

to function. He knows he must have assistance so he asks the nearest person to help. Such behavior illustrates the acceptance of the fact that he is handicapped by the disabled individual and that sometimes he must have assistance to overcome his incapacabilities.

"I used to go down to the Monks Cave. Now I had to have help to get down there and get a beer. There it was just a matter of I was with friends and those people were just helping a friend get down to a good time, and that's all there was to it."

The second method is a belligerent one. People owe me help for not planning with the handicapped in mind.

"If I'm downtown and I want to get out of my car and onto the sidewalk without going all the way around the block to a driveway somewhere, I might just say 'hey come here, help me up on the curb.' Then I rationalize and say well buddy God damn it, you didn't think about this when you had them put the curb in. I pay the same taxes you do so now you can pay for it."

This behavior and rationale appear only in the male respondents who feel a competitive business spirit and who resent being denied access to more independence.

The third method and one frequently utilized is allowing someone to offer aid, but rationalizing that the handicapped person is doing the stranger a favor by letting him help. This is a form of reciprocation. The disabled individual is then able to give as well as to receive assistance. He feels he is boosting the helper's ego by letting him give assistance when it is needed. Here one finds a humble approach to asking for help with a display of gratitude afterwards for the other person's benefit.

"When I'm in a store there might be a four inch step that I can easily hop my wheelchair over, but there is a guy walking next to me, and he is perceptive enough to know that he thinks I can't get over that so he says 'can I help you.' Well maybe I'm tired that day so I say yeah. The reason I say yeah is that it'll make him feel good to be able to help me not that I really need it."

"If somebody wants to help me and I can get up myself, perfectly able to grab on to something and get myself in good shape as well as anybody else could, I let the person who wants to help help me 'cause I feel I'm doing his ego a favor. I feel that if a person wants to help me, even if I can do it, if I let him I'm doing him a favor instead of him doing me a favor. That's exactly how I feel. Like this one lady, she was real nice, and I dropped my cane. Well it wouldn't matter, I've dropped it a thousand times. She ran over to pick it up for me. Well instead of saying no thanks, I can do it, I let her do it because I think inside myself, I'm doing her a favor."

The most frequently utilized solution to the search for independence and what I would identify as the modal pattern is the avoidance of the state of dependency. I want to stress the use of the term avoidance in this category. This is the avoidance of charity. The dependent state is a degrading one to the adult who is expected to be useful and contribute to society instead of take from it continually.

"It hurts people to need help, and the poor old cripple is shouting no, no I don't need help. I can do it myself."

"Usually people in wheelchairs don't do anything they can't do. I go downtown to certain areas because I know I can get around there. Sometimes I stray off and if I do and get in trouble--if you do get in trouble, you're prepared for it. If you need help, it's a necessity."

"I like to avoid help as much as I can. You get annoyed at over [excess] help. Things you can do and someone continually wants to do them for you is in a way degrading."

"They won't rush over like if we are hunting, and well like when I shot my deer I'm kind of proud of that. I'm one of the few guys that have been able to do that--I shot it. They came over and the deer was over in the woods probably another 50 yards from me and they didn't immediately go rushing over and drag it out for me. They asked 'do you want us to go get it for you?' If I thought I could have made it I would have said no I'll get it myself, but I couldn't so they said 'yeah, you lucky shit, shoot it then make us do your dirty work for you.' It's that kind of a relationship you appreciate."

Avoidance is achieved by taking strict precautions before a venture. Know where one is going, how to get there most easily, and if there are possible alternatives of action close by. This is where routines develop. Because this is an entire topic in itself, I shall discuss routines later in the analysis.

The importance of independence as seen by the handicapped can be best illustrated, I believe, by two final examples abstracted from the group interview between two of my male respondents.

"_____ had a hard time. At one time _____ was just down and out. He had just nothing to look forward to, and he just didn't look forward to nothing. He couldn't feed himself. He couldn't do nothing, but then finally after he got a few little things he could do well, then after he got going well it just come into bigger and bigger things. It just started a chain reaction like an atom breaking up. Now since _____ got that wheelchair, he's a lot happier I think."

"Right. That's why this chair has turned me loose so much. I don't have to depend on somebody to push me all the time. That's why this thing is worth ten times more than I paid for it. If I didn't have this now I would gladly sell my \$1,500 worth of stereo equipment and my \$400 worth of Great Books and my \$200 worth of cameras. I would trade the whole mess for a chair like this if I had to."

The child-like state of dependency is a cause of stigmatization in adults. The welfare recipient senses this in his dealings with other social classes. From the standpoint of the upper and middle classes, welfare recipients are lazy, uncouth, immoral idiots. "Only people with no pride and ambition, they think, could accept charity."³² The welfare recipient finds his word doubted, and his life strictly regulated by agency policy and by his fear of misbehaving and having his check stopped. Reciprocation by the client has been thwarted by the idea that they had nothing to contribute to social welfare. Reciprocation and its potential for adding to the client's self-respect have been ignored. Alice Overton in her article "Taking Help From Our Clients" states that "continuous taking shrinks the ego--giving expands it, provided that what one gives is valued."³³ The Protestant Ethic associating work and usefulness in our society perpetuates the stigmatization of dependency. Thus, this philosophy must be coped with by an alteration of social behavior in order to improve one's identity.

Independence behavior plays a major part in the everyday life of the handicapped. Dependence indicates a need for charity and lack of personal ability to do for oneself. They view the state of normalcy as a state in which an individual can do what he wants when he wants. Their yearning for assimilation in normal society appears to give them four alternatives of behavior in adapting to this state: (1) Simple acceptance of the need for help, (2) A belligerent acceptance of the need for help, (3) The acceptance of help with a rationalization that they are not the recipients but the givers.

³²Charles R. Atherton, "Growing Up Obscene: The By-Product of Life on AFDC," Public Welfare 27, (October, 1969), p. 371.

³³Alice Overton, "Taking Help From Our Clients," Social Work 5, (April, 1960), p. 50.

of aid, and (4) The strict avoidance of the state of dependency. Avoidance of depending is the behavior modification which brings them closest to the state of independence so it is preferred.

Self-Confidence Behavior

The problem of self-confidence came to my attention during the first interview with my second male informant. We were discussing what bothered him about being handicapped, and he claimed that his differentness bothered him the most. He wanted to be inconspicuous:

"Some of the things that do bother me are riding a three wheeled bicycle. People look at me as though I was strange 'til I get off then they can see. It don't bother me no more because I've gotten used to it. Then a lot of other things like when I fall down. One day we were shopping, my kids and I, and I slipped on my cane and my kids couldn't help me up, and they didn't know what to do exactly when they couldn't help me, and nobody else would either. I had to swallow my pride-- my kids seeing me down. I've had to swallow a lot of pride. Physically I was among the best. Mentally I know I wasn't the best so I stayed within my means. I smokejumped and dug fire lines just like you dig a ditch. I worked with the best of them. It was a great shock to wake up and just be able to move my eyeballs."

The fear of differentness appeared in my next interview with a female informant. She feared public places because she was afraid of what others were thinking of her, and how they would react to her. She was afraid people would downgrade her. However, she stated that she was her "old self" again and no longer has these fears.

Talking about capabilities and incapacabilities proved fruitful for this topic. While discussing their feelings about their inadequacies, the informants dropped clues as to how doing things in a certain manner increased their sense of capability. What future the informants saw for themselves also led to information about how the informants saw their views of the future

change as their self-confidence increased. Discussions of how the informants have changed over the years since their accidents or illness revealed the influence of significant others in their rehabilitation. The latter contributed importantly to the development of the disabled persons' self-confidence.

Physical disability as seen by these informants involved an abrupt change in social status. Each of my informants with the exception of the stroke victim was rendered unconscious by his accident and awoke in the hospital paralyzed. The socialization period came after the accident or illness. At first my informants felt as if the world had been knocked from beneath them.

"I could have done myself in or waited to die. I don't know why I didn't. They expected me to die in the hospital. They never expected me to live period. I don't know what kept me going then. I think I was very close one time. I'll remember this until I die. It was a nightmare. I think that's what it was though--death. This is getting kind of science fictional. I had a dream that I was standing at the end of a hallway and the door opened up and here was this void, blank space, nothing behind this door and I started to go in it; but I didn't. . . . But I can remember the terror that I felt, and I know that it is something that I have never felt before."

Until there was outside intervention from family, therapist and friends, the informants dwelt in the past. One informant hid in her room and refused to come out when anyone came to her home. She, as did the others, dwelt on self-pity.

"She at first thought everyone was laughing at her. She wouldn't go out of the house. If the front doorbell rang she went and hid in the bedroom. She didn't want anybody to see her. We had a terrible time convincing her, and I don't think we did it alone. She had one friend that absolutely insisted that she go out to the Village and go shopping with her. It was hard for us to convince her she wasn't a freak."

The informants needed to be shown that there was something to live for and that they could meaningfully contribute to the world in some manner. Outside intervention by significant others was needed to draw the disabled out of their self-pity. The handicapped needed to feel that there was more to life than being disabled. Thus the seeds of self-confidence, defined by Webster as "confidence in oneself and in one's powers and abilities",³⁴ were first implanted both consciously and subconsciously by significant others.

"When I was in the hospital and they expected me to die, I was not even conscious of people telling me you're going to make it. I wasn't even aware of it, but I did."

"It's the people who care, people who know you're worth something although most people don't. They give you the stamina. You feel that you're not completely worthless because these people do care. You rebel against the other people and say blank you [sic] buddy. I am worth something and I'm going to prove it."

"You have to have someone who cares to give you a little bit of positive reinforcement. It takes other people to instill it, don't you think?"

"If it wasn't for my family I'd probably be down on Woody Street. They have the enthusiasm that it takes to make me want to live and want to get well."

"Well really _____ has helped me more than I helped him. Well when _____ was at St. Pat's, I went up to his room, and he was awake I think, but I thought to myself if I ever get this way I don't know what I'd ever do. But _____ has been sort of an example for me to follow. I watched his progress through the years and then when zap I got it, then I just thought well _____ did it, why can't I. Just like _____, he can do so much in his wheelchair. He even went to some parties with us."

³⁴ Webster's Seventh New Collegiate Dictionary (Massachusetts, 1963), p. 783.

The handicapped had to be shown that there was more to life than being handicapped. Self-confidence was needed to allow the informant to put his disability into proper focus seeing himself as a person with a handicap rather than as a handicapped person. Their therapist, wives, husbands, and parents played the primary role in reestablishing the seeds of self-assurance for these individuals. They encouraged the patients to go to school, start hobbies and take an interest in their families' affairs.

Self-confidence and self-acceptance appear to be associated in these informants. Those persons with self-confidence were better able to accept themselves as persons with handicaps rather than as handicapped persons. Therefore, two modal patterns of behavior resulted. Without self-confidence the handicapped stressed avoiding presenting themselves as incapable. With self-confidence, they made a challenge of their disability by doing the unexpected. Without self-confidence the disabled individual was frightened by his incapacities and disliked to be reminded of his inadequacies so he avoided these behaviors.

"I went to San Francisco this summer, and I suppose Montana is about twenty years behind culturally--cultural lag--but I could not survive in San Francisco. I could not make it across the street. The pace is too fast. I couldn't walk up and down the streets of Chinatown because the streets were too steep. I couldn't grab onto a cablecar. It scared the hell out of me. I didn't want no part of that town."

"I don't like to watch sports anymore because I can't participate. Both of us used to love sports, but it's kind of painful."

He exaggerated his capabilities when talking to others to compensate. Similarly, a female informant said she had cooked an entire meal when in reality she had broiled the meat and someone else had prepared the vegetables.

"I clean the bathroom, wipe them down and clean the stool, wipe the floor and get down and just about didn't get up one day. It kind of terrifies a person when you can't get up, but I managed. I turned myself right over just as flat as I could; and I managed to pull myself up from that position, the prone position; but I didn't know how I was going to get up. The girl I had wasn't very big and she couldn't have helped in any way at all. I got supper last night all by myself. Oh, I had do the vegetables. I cooked the steak by myself, made the gravy myself and set the table. I have vacuumed the whole house too. Not recently though."

Finally, the person lacking self-confidence found it easier to talk of past rather than present abilities due to the fear of having to admit to present incapacilities.

"I find myself talking about things I used to be able to do 'cause it is easier to talk about them than things I can do now. I'm like an old grandpa sitting in his wheel-chair reminiscing."

With self-confidence, the individual with a disability made a challenge of his handicap. By making life a challenge, he could reinforce his self-assurance with success. The challenge was to do the unexpected-- to reduce the image of oneself as handicapped.

"I'm giving myself away here, I think before I got into the accident I was a very egocentric person. There wasn't anything I could try that I couldn't do and most of it I did well if I wanted to do it. I think this still hung on when I was in the hospital. I wasn't worried about it, I figured that if I wanted to do it, I could do it as long as I chose the right thing. I was damned sure I couldn't be an automobile race driver, but I could be a draftsman or an engineer; and even if I wanted to be a mechanic, and I knew that and I had enough confidence in myself so I wasn't really lost. The world wasn't really gone. For awhile there I didn't think I would be able to get out of the hospital bed, but that didn't bother me either because I knew I still had my mind. I could write if I had to. I could do art things. There is always something to do so I wasn't worried about that at all. It was kind of a challenge. Being paralyzed was something new, it was a challenge there."

"I had a doctor tell me I wasn't going to get out of bed, and I told him, 'You bastard you're lying to me because I'm going to get up.' Probably that's the big thing; tell me I can't do it and that's the first thing I'll try. A lot of people tell me I can't drive a car; well that's elementary. The challenge is the biggest part of the whole thing. To be able to say yeah I can work, and it's fun to look a guy in the eye and say, 'Yeah last year I got my deer. Did you get yours?'"

Defeat was accepted without doubting one's self-worth. One male patient thought he could swim. When he failed, he knew he could fly a plane because he had done this successfully since he was hurt, so he accepted this setback as a goal for the future in his recovery program. As the individual accepted a view of himself as a person with a handicap, his self-confidence allowed him to accept defeats as delays rather than as affronts to his self-concept. Without self-confidence, perceived incapacities significantly affected their behavior. The handicapped individual's self-concept then became one of a handicapped self--low ability, low worth and little future.

Beatrice Wright found a similar trend. She states that:

"When the person has a well-balanced accepting attitude towards his disability, he is more likely to feel that others question him and stare at him because they simply wonder about him--how he gets along, or how his prosthesis works . . . than when he himself is ashamed of his disability. If, however, the person basically rejects his disability and himself, he will tend strongly to resist the curiosity of others, feeling that he is being regarded negatively, with aversion and pity. His self-concept defines for him the kind of person he is as an 'object' of stimulation to others."³⁵

Erving Goffman also found self-derogation and self-pity to be the initial reaction to disability among his informants. In Stigma he quotes one informant as saying:

"When I got up at last . . . and had learned to walk again, one day I took a hand glass and went to a long mirror to look at myself, and I went alone. I didn't want anyone . . . to know how I felt when I saw myself for the first time. But there was

³⁵Theodor J. Litman, "Self-Conception and Physical Rehabilitation" in Rose, Arnold M.; Human Behavior and Social Process: An Interactionist Approach (Boston, 1962), pp. 557-58.

no noise, no outcry; I didn't scream with rage when I saw myself. I just felt numb. That person in that mirror couldn't be me. I felt inside like a healthy, ordinary person, lucky person--oh, not like the one in the mirror! Yet when I turned my face to the mirror there were my own eyes looking back, hot with shame. . . . when I did not cry or make any sound, it became impossible that I should speak of it to anyone; and the confusion and the panic of my discovery were locked inside me then and there, to be faced alone, for a very long time to come.

Over and over I forgot what I had seen in the mirror. It could not penetrate into the interior of my mind and become an integral part of me. I felt as if it had nothing to do with me; it was only a disguise. But it was not the kind of disguise which is put on voluntarily by the person who wears it, and which is intended to confuse other people as to one's identity. My disguise had been put on me without my consent or knowledge like the ones in fairy tales, and it was I myself who was confused by it, as to my own identity. I looked in the mirror, and was horror-struck because I did not recognize myself. In the place where I was standing, with that persistent romantic elation in me, as if I were a favored fortunate person to whom everything was possible, I saw a stranger; a little, pitiable, hideous figure, and a face that became, as I stared at it, painful and blushing with shame. It was only a disguise, but it was on me, for life. It was there; it was there, it was real. Every one of those encounters was like a blow on the head. They left me dazed and dumb and senseless everytime, until slowly and stubbornly my robust persistent illusion of well-being and of personal beauty spread all through me again, and I forgot the irrelevant reality and was all unprepared and vulnerable again."³⁶

Goffman identifies a pattern of socialization particularly characteristic of one who becomes stigmatized later in life. He states that the socialization pattern must involve a radical reorganization of the handicapped individual's view of his past. The disabled individual such as this, he states, has a special problem due to the fact that he has "thoroughly learned about the normal and the stigmatized long before he must see

³⁶Erving Goffman, Stigma (New Jersey, 1963), pp. 7-8.

himself as deficient. Presumably he will have a special problem in identifying himself, and a special likelihood of developing disapproval of self."³⁷

"But suddenly I woke up one morning, and found that I could not stand. I had had polio, and polio was as simple as that. I was like a very young child who had been dropped into a big, black hole, and the only thing I was certain of was that I could not get out unless someone helped me. The education, the lectures, and the parental training which I had received for twenty-four years didn't seem to make me the person who could do anything for me now. I was like everyone else--normal, quarrelsome, gay, full of plans, and all of a sudden something happened! Something happened and I became a stranger. I was a greater stranger to myself than to anyone. Even my dreams did not know me. They did not know what they ought to let me do-- . . . I suddenly had the very confusing mental and emotional conflict of a lady leading a double life. It was unreal and it puzzled me, and I could not help dwelling on it."³⁸

Goffman goes on to propose that "the painfulness of sudden stigmatization can come not from the individual's confusion about his identity, but from knowing too well what he has become."³⁹ This may be the idea which is being suppressed by my informants in their quest for self-confidence. They know that "normals" expect them to be useless, dependent burdens.

"People in wheelchairs aren't supposed to be able to do anything."

"You are treated with infant apathy."

"What are you doing out. You ought to be in your little room in the hospital. You're not supposed to be out."

³⁷ Ibid., p. 34.

³⁸ Ibid., p. 35.

³⁹ Ibid., pp. 132-33.

Lack of self-confidence appears to yield an abnormal desire to appear normal, to be inconspicuous. Differentness becomes associated with devaluation. Welfare recipients, set apart by their poverty, feel continued devaluation. They remark that store clerks look them over when they use food stamps and criticize them behind their backs. They feel spied upon by the agency and as if no personal decision or act is their own. Having to be continually accountable for their financial and moral status produces a constant strain on their lives. An excellent example of the wish for a higher self-evaluation occurs when a person comes to the agency for his first visit. The following is a hypothetical account compiled by William Tarnower, a psychiatrist, about a client's first visit.

"It may sound silly to you, but I feel uncomfortable coming here today. I know you are here to help me, but I feel anxious. I feel ashamed. I wonder what my friends would think if they knew. They have troubles too, all people do, but they can work it out by themselves. I would be humiliated because my friends might think that I was weak or crazy."⁴⁰

By going to the welfare office the client is admitting his inferiority to himself. Many clients arrive dressed in their Sunday best, or try to conceal humiliating social data such as men in their home. This is their method of trying to raise their social status closer to normalcy.

My informants yearned for positive reinforcement of their worth and ability. The first modal pattern of avoiding incapacibilities helped them reduce their insecurity temporarily. As self-confidence increased, making a challenge of the disability (doing the unexpected) added to the feeling

⁴⁰ William Tarnower, "The Experience of Seeking and Receiving Help," Public Welfare 27, (October, 1969), p. 377.

of overcoming one's real and perceived inadequacies and replaced avoidance as the new modal pattern.

One-Upness or Competitive Behavior

It wasn't until my second series of interviews that the desire for superiority or one-upness as I call it appeared. This behavior was uncovered when I began inquiring about the individual's coping skills. "How do you think you cope with being in a wheelchair?" "Have you developed any skills in order to be as normal as possible?" The initial reply was "vast patience and resignation. My day is coming, my turn will come." This did not indicate to me a behavior, but it did point out desire for superiority which I felt might become evident in behavior patterns of the handicapped.

This proved to be the case as I pursued the personal accounts of how these individuals modified their behavior to illustrate the desire for superiority. One informant described how he felt after he fell down and the nondisabled walked by without offering assistance. This was when he revealed his feelings about doing other peoples' egos a favor by letting them think they are helping him when in reality he needed no aid.

Another mode of questioning which was useful in this area was the idea of what made life worthwhile for these individuals. What made life fulfilling for them? Here the answer was "you can do it and you want to show them you can." My informants felt that this gave them self-respect. Feelings against the discrimination of the handicapped by the nonhandicapped population also added understanding to this category.

"The only thing that's going to hurt me is not my ability, but it will be people's ability to accept me for what I am. You have to sell yourself and do a better job than the ordinary person would have to do to overcome this. A good example of how it is--when you go into a room for an interview, a person in a

wheelchair is always the last person to be interviewed usually because he is the last person seen. He is down sitting low. You are the last person interviewed--then when you get in there damn they are so sick of listening to people. Then the guy's own pride is there, too. Usually you are interviewing for his job or something close to it, and they look at you and say 'God, you can't do my job. How can anybody in a wheelchair do what I can just barely do.' This inferiority thing. People in wheelchairs just aren't supposed to be able to do anything. When you go to compete for their job, it makes them look bad in their eyes."

The search for positive recognition or the idea of sell yourself appears to be the dominant force behind one-upness or competitive behavior.

"It's hard enough to sell yourself in the everyday world when you haven't got a handicap. You have to be good, but you have to be even better when you're in a wheelchair or have any other physical handicap that is readily identified."

"Just like you go out and you have something to offer, goods to sell. If you can't sell yourself, you can't sell your goods. If you can't sell your goods you don't work. People look at you for what you are physically not so much mentally."

My informants felt themselves compelled to decide on a course of action and to direct all their efforts towards the completion of the goal whether it was a career, play activity, or learning to walk again.

"Right now we are both forced into a position to know where we want to go. We can't just float and work at the sawmill you know. We are put in the position where we must be more aware of our surroundings like you said, and we have to decide where we want to go. That's the big difference."

"I had a doctor tell me I wasn't going to get out of bed, and I told him, 'You bastard you're lying to me because I am going to get up.' Probably that's the biggest thing. Tell me I can't do it and that's the first think I'll try."

They felt compelled to fight back against society's stereotype of a handicapped person in order to prove that they were people like anyone else who had a handicap. They realized that there were many crippling disabilities other than the physical ones.

"I look at some of these people who can walk, jump, dance, and sing. I always use that expression because it's the best way to put it for me. I look at the people and shake my head and say I'm not handicapped. I'm not screwed up, they are. There are a lot of people around I wouldn't want to change place with."

By competing and seeing themselves as better than the nonhandicapped or by succeeding in defying the stereotype of the handicapped, my informants built up their self-images.

"You don't sit down and say well, I'm going to do this and this and this in the next three months and that way I'll feel that much better about my self-concept. You just have to fight back or else you're nowhere."

There are social barriers and my informants felt compelled to "drive right over the top or they'll kill you." By social barriers they meant society's attitudes towards the handicapped. One example two of my male informants used was the fact that they were two of the few from their high school who went to college.

"_____ and I come from a mentally deprived area. I think maybe fifteen of our class went to college. That's about all. That gives _____ and I a source of pride."

"Sure I go down to _____ club to get drunk with the boys and I look around and half of them haven't finished school--high school."

"... It's fun to look a guy in the eye and say 'Yeah last year I got my deer. Did you get yours?' I know damn well they didn't get it, and I watch their reaction. That's probably the biggest thing to be able to do something and knowing that people expect you not to be able to do anything and then to pull this thing off."

To my informants, being recognized as superior or equal (because the disabled felt they had to be better to be given an equal chance) meant to be "making it in society." This meant that one was an accepted, participating, contributing member.

"I have a function in society. If I don't, I'm dead. Man is a social animal. I'm more social than most. What people think of me is very, very important. Possibly because I am so dependent on them. I don't know. I have to look good in my eyes, and I think the way to do this is to look good in someone else's eyes. You don't know how good I felt when I read in our good old local paper last week that _____ had graduated with honors. I knew what I had gone through. A lot of people don't realize how hard it was for me to get through, but I knew and this was for me baby, you know. I can't get a job with my B.A. right now, but that's not important. The important thing is I proved it to myself and I went through some real weird stuff, you know like when for a couple of quarters I had to stay down until eleven at night. The fellow I rode with had to work swing at Van Evans from three to eleven. . . . It bothers me when I don't feel people appreciate what I've done. You know my reward is through society's eyes. . . . I do feel good if I accomplish anything myself whether anybody knows about it or not, but if somebody else does notice it I feel just that much better."

Erving Goffman labels the attempt to compete or prove oneself as one method used by the stigmatized to overcome their position in society. Goffman identifies two methods. The first or direct method is that of surgery or treatment to repair the damaged parts as successfully as possible. The second method which I am concerned with is an indirect response to the situation.

"The stigmatized individual can also attempt to correct his condition indirectly by devoting much private effort to the mastery of areas of activity ordinarily felt to be closed on incidental and physical grounds to one with his shortcoming. This is illustrated by the lame person who learns or re-learns

to swim, ride, play tennis, or fly an airplane, or the blind person who becomes expert on skiing and mountain climbing."⁴⁰

Goffman also noticed the trend towards reassessment of the limitations of normals. By realizing that all persons are handicapped by one deficiency or another, the disabled individual is able to lift his social status in his own eyes.

"Both healthy minds and healthy bodies may be crippled. The fact that 'normal' people can get around, can see, can hear, doesn't mean that they are seeing or hearing. They can be very blind to the things that spoil their happiness, very deaf to the pleas of others for kindness; when I think of them I do not feel any more crippled or disabled than they. Perhaps in some small way I can be the means of opening their eyes to the beauties around us: things like a warm handclasp, a voice that is anxious to cheer, a spring breeze, music to listen to, a friendly nod. These people are important to me, and I like to feel that I can help them."⁴¹

Goffman points out that the usual scheme of interpretation by "normals" for everyday events is upset by the fact that they are interacting with a disabled person. Minor accomplishments may be assessed as remarkable abilities. On the other hand, minor failings become a direct reinforcement to their viewpoint that the stigmatized individual should be set apart as different and inferior.⁴² Thus one must avoid failure in the sight of "normals" and increase one's positive or successful contacts with them. The idea is sell yourself although Goffman does not use this term.

The handicapped are keenly aware of the need to prove their ability and worth in areas they still control. By emphasizing capabilities, it

⁴⁰ Ibid., p. 10

⁴¹ Ibid., p. 11.

⁴² Ibid., pp. 14-15.

is hoped that the incapacities will be forgotten or at least repressed in order to allow the disabled individual to participate in "normal" society. Sell yourself to the nonhandicapped is the modal pattern of behavior in the area of competitive behavior.

Routinized Behavior

The question of routinization came up when I began to wonder how these individuals coped everyday with their handicapped situation. Did these individuals have a set routine to get them through the day? How did they feel about it? How would they want to change it? Is the routine challenging? Exciting? Why did they have a routine at all?

I began my second interview by asking my informants to describe what they could do and could not. Then I asked them to describe for me what kinds of behavior they would like to be able to do most. This gave me an idea of how these people felt about their abilities and incapacities. The cue to routinization came indirectly from my first informant. I asked him to describe everything that happened to him the day before from the time he got up until he went to bed. His response was, "you have to remember that I am learning to live with my handicap so everyday isn't tumultuous as it was in the beginning." This indicated to me that his methods for coping with his handicap had become so familiar or routine that he failed to consciously think about each movement as it was made. This meant I had to make him think about this familiar behavior critically in order to get him to think about it analytically. I asked the informant to describe his routine. As he did this I noticed him begin analyzing it himself automatically. It was as if he was looking at it through my eyes as a normal so it became strange through this other viewpoint. The informant became progressively analytical as he became more adept at seeing himself through my eyes.

Caroline: "Can you tell me about your routine?"

Respondent: First thing when I get up in the morning I put on my socks first because I got to put on my socks a special way. My toes cannot point so I cannot put my sock on the usual way. I can't use my right hand to do it hardly. So I just spread it at the top and put it on my foot. This process used to take me when I first got home about fourteen minutes to put my shoes on. Now I can be dressed and have a pot of coffee and be shaved in that time. That's one thing I wish I could do but I can't. That's in the routine I learn to live with.

Then I come in to the kitchen and I clean up. I walk around the kitchen without my cane because I can bounce off everything. The kitchen is small. I cannot get dishes out of the cabinet because I get this hand up to hold one dish and pull another.

I ride my bike over to school. I got to lean against the building to get my foot over the bar. It's a girls bike but I got to lift it up then I peddle down to school. I got to park next to the buildings that got those little benches to get off my bike so I have something to lean against. I walk into the building. Yesterday and today I have been trying to . . . I got stairs to go up in the Forestry Building so I have been trying to walk up one foot in front of the other. Instead of the same foot each time. I do all the physical therapy I can that I think will help me in a day.

Caroline: This is something that most people don't have to think about it just seems natural to them to put one foot in front of the other, but you have to think about each step before you take it.

Respondent: Yeah, one other thing when I get a drink of water I have to think to swallow all the time. It's such a simple little thing in life that people don't think to swallow. I have involuntary muscles. I have to roll it to the back of my mouth I have to be careful there or I choke. So I chew alot of gum to keep alot of juice in my mouth so I have to do alot of therapy alone if only I had the discipline to do it. In fact I can't believe I was actually in a wheelchair. I don't know why anybody would ever want to be in a wheelchair, I can't imagine. I punched that damn thing out of here. I can't imagine why anybody would want to be on crutches, but this winter I'll probably be back on them after I take a few spills on the ice. I feel equal to any other person. I get a little up tight when I see something spectacular that I think I could have done better. I find myself talking about things I used to be able to do 'cause it is easier to talk about them than things I can do now. I'm like an old grandpa sitting in his wheelchair reminiscing. That's bad."

My informants felt themselves spurred into a routine which enabled them to be as "normal" as possible.

"I'm in a so-called normal society; and the only way I am going to survive is to acclimate myself to the normal society. The society I want to live in is the thing. No doubt I can live, exist, by doing absolutely nothing, but this isn't the role I have chosen for myself and that society has placed upon me that I feel . . . you know this whole Protestant Ethic bit where you know man has to work in order to be useful. . . ."

Their direction was to work for "normalcy" and this was a day-to-day goal. Why was it day-to-day? For my informants little everyday tasks were a mountain to be climbed, a hump to be overcome. Nondisabled were able to take these tasks for granted because of their high levels of efficiency. However, the handicapped with their limited capabilities had to plan ahead each action each day to try to promote success. They planned on a daily basis because looking too far ahead led to greater odds of failure due to the need for skills not already perfected.

"If I look too far ahead, it gets scary because the way the world is today I can live in it, but the way it might be tomorrow I just might not be able to."

The handicapped cannot cope with radical changes as rapidly as the nonhandicapped. They have a limited ability to change physically. Above all, the handicapped are more aware of the chances for something to happen to hinder their progress.

"The chances are very slim that someone is going to jump in a lake and break their neck. The chances are very slim that somebody is going to fall under the fender of a car that's going to roll on his head, but this had already happened to us so we know that these odds do exist. This is kind of on the back of your mind. This happened once; what else can happen? We're a lot more aware of this than other people I think."

The handicapped feel that they have to take more into account consciously to act as "normal" as possible.

The handicapped routine appears to have four major characteristics. It is planned ahead of time; planned daily, inflexible and many times includes others into it. This last point is one of uncomfortableness for the disabled. They want to promote independence as much as possible, but in order to be able to perform many of society's tasks of which they are incapable alone, they feel compelled to accept help.

My handicapped informants appeared to seek regularity and predictability of behavior because above all they feared having no control over a situation. They feared the insecurity of unfamiliar places because they could not be sure of the facts that needed to be taken into account to cope with the situation and could not adequately plan ahead. The disabled could be physically abused and have no method of defense. They could get into a situation physically where they were unable to help themselves and no one was near to help. By utilizing a routine, my orthopedically handicapped informants knew what they were capable of, how long it would take, and what precautions were necessary for success. This allowed them to protect their new disabled-self concepts. Success reinforced their self-confidence and routines helped promote success.

Erving Goffman would classify routinization, I believe, as a form of covering. Covering is an adaptive technique used to reduce tension and to make it easier for the stigmatized to sustain "spontaneous interaction" by withdrawing attention from the stigma.⁴³ One type of covering

⁴³ibid., p. 102.

involved "an effort to restrict the display of those failings most centrally identified with the stigma."⁴⁴

"The most interesting expression of covering, perhaps, is that associated with the organization of social situations. As already suggested, anything which interferes directly with the etiquette and mechanics of communication obtrudes itself constantly into the interaction and is difficult to disattend genuinely. Hence individuals with a stigma, especially those with a physical handicap, may have to learn about the structure of interaction in order to learn about the lines along which they must reconstitute their conduct if they are to minimize the obtrusiveness of their stigma."⁴⁵

The stigmatized therefore seek to reduce their differentness by concealing inadequacies or failures. By perfecting certain behaviors and emphasizing these to the exclusion of imperfect behaviors, the handicapped appear less stigmatized or strange to normals. Thus by shopping only in certain areas where one knows he can maneuver best independently or by dismounting a bicycle in a particular manner, one tries to minimize his real and perceived incapacities by emphasizing his capabilities.

Routinized behavior appears to help the stigmatized in general to decrease his self-consciousness about being labeled inferior. He alters his behavior to stress those which minimize his stigma. The welfare client shops only in those stores which are within his budget. He avoids middle class department stores because his incapability to pay cash and the need for credit would reveal his flaw. He eats in particular restaurants or drinks in particular bars where other recipients congregate in order to feel comfortable and enjoy himself.

⁴⁴ *ibid.*, p. 103.

⁴⁵ *ibid.*, pp. 103-04.

Fearing uncontrollability, unpredictability and irregularity, the physically handicapped stress routines in their daily lives. Rigid schemes of action, planned ahead of time daily and taking others into account if needed, become the modal pattern of routine behavior. One's differentness can thus be predictably disguised by the planned stress of one's remaining abilities.

Escape Behavior

My discussion with Phyllis Bagely, therapist at the Missoula Crippled Childrens Center, revealed the difficulty that these informants have had in accepting themselves as disabled individuals. She explained how these people went through a period of depression after their accidents or illness in which they felt "completely knocked down." They expressed the feelings, "Why did this have to happen to me? If there is a God, why did this have to happen to me?" The struggle to motivate these individuals involves getting them interested in areas other than themselves. But, the struggle is not easy. The handicapped individual must learn to accept himself as a person with a disability who has value, worth and purpose, and not identify himself as a disabled person, inferior and useless. Miss Bagely gave one personal experience she had with one of my informants to illustrate the frustration involved in accepting oneself as a person with a disability.

"Her attitude has changed completely. She at first had self-pity and was self-centered. Now her interests are going outside of herself. She is becoming interested in more things even if it's checkers, company and children graduating. She's beginning to realize that there is more besides just being handicapped. She's thinking beyond herself. Although I asked her the other day, what if you could never use that hand again, and I knew I hit a real bad point, and she kind of clouded up a bit and said, 'I will use that hand.' It's easy to throw her into a state of depression and feeling sorry for herself. You must remember that as a well person she was real dynamic, hyperactive, going all the time."

After my discussion with Miss Bagely, I began to look for ways in which my handicapped informants coped with this difficulty in accepting themselves as persons with handicaps. Discussions of what they could do and could not do revealed the informants' feelings towards their disabilities. Just talking about their present behavior and past experiences yielded some introspection on the part of my informants as to why they acted as they did, and how they must accept their disability.

"The first time I went swimming I knew I could swim so I waded out as far as I could go, threw away my crutches, started to swim and sank. It took three people to drag me in. I just can't wake up to this reality."

One informant related his present dating behavior describing how his conflict in feelings between how things are and how they could be if he were not disabled affected his dates.

"Any girl I meet, especially if she appeals to me at all, if she is attractive to me at all, well, I sit there and get all tangled up in the way I wish things could be with some girl which screws up the relationship because I'm always looking for more, you know."

I found a wish for complete recovery among those who had been disabled for the shortest period of time. One continually claimed she was her "old self" again to symbolize this. However, "old self" is a fiction. It can never be attained again because a person is different simply by experiencing the injury or illness. Self is a continually changing, ongoing process not a permanent structure.

According to Symbolic Interaction theory, the self is a process whereby the individual becomes an object of his own action. He directs his actions, utilizing the cues he receives from others and his own preconceptions of a

phenomenon. As cues change the self must be altered taking these into account. (See discussion of Symbolic Interactionism, page 55.)

Escape behavior of three kinds is the most prominent method of coping with the difficulty in accepting a disabled self. The first and least employed is that of retreatism. Two of my informants choose to withdraw from society and not participate. One does to a greater extent than the other. One male respondent lies in his bed waiting to die. He feels he has little to live for. His wife divorced him. His children have succeeded in getting an education without his support. According to his therapist, he was a semi-recluse before his accident. He was shy, retiring and a loner. He has withdrawn further from society with his physical disability. In the other instance, a female informant refused to shop in Missoula where she might meet her past friends who knew her before the accident. They would recognize her deficiencies, and she would become more aware of them through their eyes. According to Symbolic Interaction theory, the meaning things have for a person arises out of the ways in which other people act toward the person with regard to the things. Past friends would look at her new capabilities and label what she could no longer perform as deficiencies so she would feel more inferior. (See discussion of Symbolic Interactionism, page 53.) Seeing them would also remind her of her nondisabled life before and this was painful. She avoided most contact with previous friends. An interesting point is that this girl will shop in Great Falls or Spokane where she is not known. Perhaps she feels less threatened when she does not have past abilities to live up to in her interaction with strangers. She feels more apt to be accepted on an equal basis in spite of her disability by these individuals who did not know her previous capabilities.

The second form of escape and one used more often is that of role pretending. To the handicapped, this means living the life of a nonhandicapped person in one's imagination. One can overlook incapacibilities by mentally completing tasks one is unable to perform. For instance, a woman claims she prepared the entire dinner when in reality she only broiled the meat. To avoid facing the reality, one can "dream" of the way things could be if he or she were not disabled.

"It's like watching an old-time movie in your head where the good guy wins. It's a way of escaping the parts of reality you don't like."

The pretended behavior is accomplished internally. Only the handicapped individual experiences the escape.

The final type of escape, which I will call the modal form of escape, I found present in each informant. There was a conscious effort on their part to "make it" in the nondisabled society. In order to accomplish this, they avoided as much as possible identification with other handicapped individuals. The handicapped know each other on campus, but rarely are they seen together. None of my informants expressed a desire to work professionally with other disabled individuals. They expressed a desire to be guidance counselors in public schools, school principals, personnel managers. All of these occupations are in nonhandicapped society.

"I'm in a so-called normal society and the only way I am going to survive is to accclimate myself to the normal society."

The handicapped avoided signs of a handicapped person--crutches, wheelchairs, braces, as much as possible.

"To me if there was any way in hell or heaven that I could function without this thing (wheelchair); you'd never catch me in it again period. I don't care what it is."

"I was in a wheelchair from December of '67 until September of '68. Then I got on these crutches. Then from there I'm trying to master the cane now. . . . In fact I can't believe I was actually in a wheelchair. I don't know why anybody would ever want to be in a wheelchair. I can't imagine. I punched that damn thing out of here. I can't imagine why anybody would want to be on crutches, but this winter I'll probably be back on them after I take a few spills on the ice."

The disabled also avoid contact with the "hopelessly handicapped"--persons born with lack of control of their bodies such as cerebral palsy patients. Spastics, for instance, are hopelessly ethnic. They will never be able to pass over the marginal status border into nonhandicapped society. The handicapped demonstrate the same fears towards the spastic that a nonhandicapped person feels towards a handicapped individual. It's like a fear of catching a disease. Somehow by associating with a stigmatized individual, it is feared that this stigma will rub off, and you will become stigmatized. The handicapped fear further stigmatization. Their wish to be granted "normal" status is one of the greatest motivations in their lives.

Erving Goffman, in his discussion of passing, points out the awareness that upon leaving a social community and entering a new one, an individual hopes to be able to drop his previous identity and begin another.

"When an individual leaves a community after residing there for some years, he leaves a personal identification behind, often with a well-rounded biography attached, including assumptions as to how he is likely to 'end up.' In his current community the individual will develop a biography in others' minds too; potentially a full portrait including a version of the kind of person he used to be and the background out of which he came."⁴⁶

⁴⁶ Ibid., p. 78.

This new identity has the potential of being untainted by one's past record if certain facts are hidden. Thus refusal to identify with the symbols of disability (crutches, wheelchairs, etc.) and with persons of tainted status enhances one's ability to make a favorable impression on new comrades. This may explain also why my handicapped respondents have noticed themselves drifting away from friends who knew them before their impairments. These individuals will perhaps tend to judge them by previous performances and thus increase their sense of incapability.

"Sure, the friends I have now have accepted me in this thing and it's the only way they know me; and the people know me, on a completely different basis."

Stigmatization involves involuntary devaluation. The stigmatized individual receives cues from the nonstigmatized that he is inferior while his own perceptions indicate he has value and usefulness. Again using the welfare client as an example, the welfare recipient also has difficulty accepting the disabled self concept thrust upon him by middle and upper class society.

"Sometimes I take things from other people, but I resent having to do that. It makes me feel guilty. I hate myself for caring what they do or think in regard to me. So, even though I want what you give me and take it, I try not to want it. I feel cheated that I wasn't given a fair share to begin with. Others are valued more and are given more. I used to feel that I rode on the backs of others; but now I realize how they have ridden on my back. They say I'm a selfish son-of-a-bitch, self-pitying, but they have taken everything from me--my pride, my sense of worth."⁴⁷

Welfare clients react to this inconsistent evaluation with a desire to escape the situation. Sometimes this takes the form of apathy. At other times there

⁴⁷ William Tarnower, "The Experience of Seeking and Receiving Help," Public Welfare 27, (October, 1969), p. 378.

is a physical move to try to start anew where one is an unknown. It appears that when society singles out a minority for differential treatment and the minority group disagrees with the evaluation inferred by this treatment, a method of coping is to refuse to accept this evaluation and escape those situation perpetuating it.

Physically handicapped individuals have difficulty accepting their disabled self concepts and therefore escape from the reality of their disability. Three types of escape behavior were recorded--retreatism, role pretending, and avoidance of all signs of disability. Again the stress of capabilities leads the handicapped to reject identification with all visible symbols of stigmatization including association with other disabled individuals and physical aids such as crutches, wheelchairs and braces. This then becomes their modal pattern of escape behavior.

Presenting Self Differently Behavior

Question: "How do you think you cope with being in a wheelchair? Have you developed any skills in order to be as normal as possible?"

Answer: Vast patience and resignation.

Question: Can you explain that? How do your patience and resignation show in the way you come on to other people when you are sitting in your wheelchair?

Answer: For one thing, I cannot physically withdraw from a situation that is unpleasant so I learn just to bide my time, to keep my mouth shut if possible. I cannot physically abuse people to protect myself so I have to learn to keep my mouth shut. I can't demonstrate overtly, you know, by walking towards somebody or holding hands to the same extent that other people can. I have to cope with this to display my feelings adversely or positively in other manners I still have control over [sic]."

It was this response that started me thinking in terms of how these handicapped individuals expressed themselves to others. What methods were

they still able to utilize in order to respond in the nonhandicapped society? Past physical means were no longer available to them. How did they compensate for this loss?

One method utilized frequently is that of verbalization. The handicapped are still able to communicate orally so more emphasis is placed on this skill. Verbalization becomes the manner in which these persons "sell themselves" to employers, get necessary aid, make love, rebuke offenders and escape. One respondent felt himself "trying to verbalize everything like a used car salesman." An important point here is that verbalization becomes both an offensive and defensive action--by talking tenderly these informants make love, by talking in a complex or ambiguous manner above the other person's ability to comprehend these individuals avoid further conversation.

"I intellectualize. . . . It's my way of not displaying my true emotions. I put up a big fog that covers up the part of me I don't want to show or that is very tender."

Just by talking about subjects others know nothing about, the handicapped can get them to change the topic of conversation to a more equal basis of communication or stop a conversation altogether.

Above all presenting self differently appears to involve the development of the skill of patience. One informant expresses this in the form of pride.

"I've swallowed a lot of pride on my way. I've told you before physically I wasn't among the best, but I was among them, and pride is one thing I got to hang onto. I take pride in what I am right now. You got to have this personal pride. It hurts people to see a handicapped person fall down. It hurts them in a way, but they don't know what to do so they walk on by."

Patience is the ability to bide one's time; to wait for action with the belief that your turn will come. The physically handicapped cannot protect themselves from physical abuse so they must keep silent when provoked or risk injury.

"You learn to laugh 'cause you know sometimes people can be cruel and you've got to laugh now because you can't go punch them in the nose. If they ever punched you back, they'd kill you."

They must develop a different sense of time. By this I mean that they must be content to wait longer for results. They are forced to put forth a greater effort to sustain interaction with the nondisabled because their (nondisabled) first inclination is a superficial, protective interaction.

"It's the costs I'm willing to put up with to get any kind of interaction beyond just passing in the hall. I have to put out a little more and if I'm willing to do that well I can have as meaningful a relationship; I won't say that, a conversation as anybody else."

My informants found that in order to reach their goals they had to move forward one small step at a time.

"We're forced to apply ourselves in some direction and try to move in that direction one day at a time."

When previously routinized means of presenting oneself publicly become thwarted, new means must be sought. These new methods will tend to be those which stress one's abilities and strengths in order to present a favorable picture to one's significant others. Presenting Self Differently behavior is thus displayed in two behavior patterns of the handicapped. Verbalization is the direct means by which the handicapped compensate for their loss of physical ability. The disabled must learn to substitute verbal skills for

the physical in order to sustain interaction of all types. The modal behavior pattern, however, appears to be the display of patience. This involves a new sense of time, effort expended, and direction. It is a waiting behavior with the belief that one's turn will come.

SYMBOLIC INTERACTION AND THE HANDICAPPED

A discussion of the three major premises of Symbolic Interaction as proposed by Herbert Blumer will corroborate, I believe, explanations of the reasoning behind the actions of the handicapped in their modal patterns of face-to-face interaction. The premises are as follows: (1) "human beings act toward things on the basis of the meanings that things have for them, . . . (2) the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows, . . . (3) these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters."⁴⁸

Without meaning human beings have no reference as to how to act towards something. This meaning is formulated through social interaction. "The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define for the person."⁴⁹ If many people act toward something in a similar manner, then the individuals possessing this thing, a similar physical handicap in this case, will have similar impressions as to the meaning of their characteristic. The individual "by virtue of this process

⁴⁸ Herbert Blumer, Symbolic Interactionism (New Jersey, 1969), p. 2.

⁴⁹ *ibid.*, p. 4.

of communicating with himself, . . . selects, checks, suspends, regroups, and transforms the meanings in the light of the situation in which he is placed and the direction of his action."⁵⁰ Herbert Blumer interprets George Herbert Mead as defining symbolic interaction "as a presentation of gestures and a response to the meaning of those gestures."⁵¹ Thus, individuals take on cues from the gestures of other persons and organize their responses on the basis of those cues. "The person who responds organizes his responses on the basis of what the gestures mean to him; the person who presents the gestures advances them as indicators or signs of what he is planning to do as well as what he wants the respondent to do or understand."⁵² Mutual role taking becomes important in this process of interpretation for different things have different meanings according to the people involved and the situation. "Parties to such interaction must necessarily take each other's roles. To indicate to another what he is to do, one has to make the indication from the standpoint of that other; to order the victim to put up his hands the robber has to see the response in terms of the victim making it. Correspondingly, the victim has to see the command from the standpoint of the robber who gives the command; he has to grasp the intention and forthcoming action of the robber."⁵³

The orthopedically handicapped experience a double burden. Besides the cues taken from current gestures toward them by the nonhandicapped,

⁵⁰ *Ibid.*, p. 5.

⁵¹ *Ibid.*, p. 9.

⁵² *Ibid.*, p. 9.

⁵³ *Ibid.*, pp. 9-10.

the handicapped have assimilated and retained the past meanings that they themselves had as nonhandicapped individuals.

"The painfulness of sudden stigmatization can come not from the individual's confusion about his identity, but from knowing too well what he has become."⁵⁴

The self in Symbolic Interaction is viewed as a process not a structure. The self provides the human being with a mechanism of self-interaction whereby the human being becomes the object of his own action. He "can designate things to himself--his wants, his pains, his goals, objects around him, the presence of others, their actions, their expected actions, or whatnot. Through further interaction with himself, he may judge, analyze, and evaluate things he has designated to himself. And by continuing to interact with himself he may plan and organize his action with regard to what he has designated and evaluated. In short, the possession of a self provides the human being with a mechanism of self-interaction with which to meet the world--a mechanism that is used in forming and guiding his conduct."⁵⁵ The process of self-interaction requires that a person cope with his world not merely respond to it. "It forces him to construct his action instead of merely releasing it."⁵⁶

The orthopedically handicapped construct their behavior according to the cues they receive from the nonhandicapped; their own preconceptions of what it means to be handicapped; and their conceptions of what they would like to be. The handicapped having lived among the nondisabled have the

⁵⁴Erving Goffman, Stigma (New Jersey, 1963), pp. 132-33.

⁵⁵Herbert Blumer, Symbolic Interactionism (New Jersey, 1969), p. 62.

⁵⁶*Ibid.*, p. 64.

same goals as the remainder of society. They identify with nonhandicapped observing the discrepancy between the cues given between two nondisabled persons and disabled and nondisabled individuals. The disabled yearn for equal status and much of their coping behavior is motivated by the desire to take on the role of the nonhandicapped person in society. The escape behavior revealing a difficult accepting their disabled self concepts is a reaction to the unequal cues given them. The avoidance of further identification with other handicapped individuals and avoidance of the symbols of disability are attempts to modify the meanings others garner from the handicapped persons' appearance and behavior. By modifying and restricting their behavior which might be construed negatively by the nondisabled, the disabled hope to elevate their status to a more equal position.

CHAPTER 5

SUMMARY AND CONCLUSIONS

The orthopedically handicapped in this study appear to have six categories or modal patterns of face-to-face interaction. (1) Independence behavior is characterized by the avoidance of dependent relationships. (2) Self-Confidence behavior varies according to an abundance or lack of self-assurance. With a lack of self-confidence, there is a tendency to avoid incapacities and exaggerate capabilities. When self-assurance is strong, the handicapped individual makes a challenge of his disability. (3) One-upness or competitive behavior is characterized by the search for positive recognition (emphasis on sell yourself). The handicapped person looks for opportunities to demonstrate his capabilities in order to prove his right to equal social status. (4) Routinized behavior is a plan to insure regularity and predictability of action. It is an effort to reduce one's differentness repeatedly. (5) Escape behavior is highlighted by the avoidance of identification with symbols of the stigmatized position. (6) Presenting Self Differently behavior involves above all the cultivation of the skill of patience.

The modal patterns appear to be similar for each of my six informants with slight variations by age and sex. This may be in part due to the fact that norms vary by age and sex in the nonhandicapped society, and an individual will identify with those of comparable age and sex. The modal patterns are all centered around the problem of identification with the nonhandicapped society and a desire to be granted equal social status by this group. Because their traditional taken-for-granted techniques of interaction are no longer available, the handicapped are forced to seek new means of gaining acceptance.

Involuntary stigmatization increases self-consciousness in an individual due to the fact that the devaluated person wants to believe he

is not inferior while his cues from his significant others indicate the contrary. To improve his status, the stigmatized individual emphasizes those behaviors valued in the nonstigmatized group. This in itself can provide clues as to what the goals are of the nonhandicapped society and what the traditional methods are for attaining them. Nonhandicapped society stresses independence and usefulness. These appear to be attained through an identification with one's work and recreation. The emphasis on competitiveness in work and play attests to this. Through the modification of their capabilities, the handicapped attempt to simulate many of the taken-for-granted behaviors of the nondisabled society. Recreation, shopping, applying for job and dating become problematic to the handicapped individual and must be dealt with.

On the basis of the commonality of responses, I believe that this study reveals that orthopedic disability does lead to similar compensatory mechanisms due to similar learning experiences. However, this study only supports this claim for the orthopedically handicapped. Further research should examine other types of disabilities to find out if this claim still holds true for welfare clients, emigrants, the blind, etc., in order to verify Goffman's claim that similar disability leads to similar compensatory mechanisms of behavior. Goffman suggests that the blind, the poor, etc., will have similar methods within their own groups. Also age span and sex should be further investigated. By tightening these variables finer variations of modal patterns may become apparent and information of this type would be extremely valuable to physical therapists and the primary socialization agents (parents, spouses, etc.) in helping the handicapped adjust to their limited physical equipment socially. One last suggestion is that the scope of the study be increased to include more informants. This would increase the validity of the findings by allowing

for more comparisons according to the constant comparative method of Glaser and Strauss.

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APPENDIX A

The following is a group interview held between myself and two male informants. Names and identifying places have been concealed in order to protect their identities. These respondents grew up together in Montana and although they were injured in separate accidents, they have shared many common experiences.

C: 'What does it mean to you to be stigmatized in this way?

1: I think I know where I'm going now where I didn't know before. That thing is good, but I still would like to run, jump, sing, and dance and raise hell. It's been really good for me. I went too fast and have no remorse. But I can say that because I can still get around.

C: What does it mean to you (2)?

2: If I had my druthers, I'd rather be someplace else. But it's part of life. You do what you have to, Caroline. They tell you all this crap about how people are stronger when they have to work harder and all this crap. I think it's probably true because I didn't know where I was going either. I doubt if I'd have ever gone to college the way I was before. I know you wouldn't have (1).

1: I wouldn't have been here. When I talked to (2) that one day it sounded like a pretty good deal. I was over to see (2) after I came home.

C: (2) was already in school?

1: Yeah, he sort of put me straight.

C: Do you think that since this happened you are more aware of who you are and where you are going?

1: Oh yeah. I tell you I'm more aware of my surroundings now. It was just like I had tunnel vision before, now I got the overall picture of everything and I can see how phony some of everything is going some-times. How phony people really can be when you are down and out. (2: Right.) and I can also tell that when you get knocked down and in the position that (2) and I are in, you'll find that you'll lose your friends and that when you're knocked down you'll get kicked some-times. Just like you go out and you have something to offer, goods to sell. If you can't sell yourself, you can't sell your goods. If you can't sell your goods, you don't work. People look at you for what you are physically not so much mentally. Like (2) could probably do pretty good on his own. They're giving him the run around at the vo-tech now only because he's in the chair. That's the only reason. Now them kind of people's got to be straightened out that's all. [sic] Like I say a minority group such as us, we ought to be raising hell too. We ought to band together in one state--all the paraplegics, quadraplegics, all the handicapped people in one state, declare it a disaster area and apply for foreign aid.

2: Declare a war, (1), war against the U.S. then lose.

C: Then you'll get recognized!

1: But I mean for my own personal self I don't have any remorse, but for my family, and what I'm supposed to do for my family, I do. For the peg I am supposed to be in society I lack a little because I can't quite keep up with the Jones because they can walk, jump, dance and sing. Otherwise it don't make any difference to me. My family is the most important thing to me. I don't give a damn about anybody else. As soon as I can be a provider again, the happier I'll be. Now I know where I'm going and I have a good program to go under.

2: That's it. Right now we are both forced into a position to know where we want to go. We can't just float and work at the sawmill you know. We are put in the position where we must be more aware of our surroundings like you said and we have to decide where we want to go. That's the big difference.

C: Physically or go in the sense of the future? What do you mean?

2: You can't dichotomize them.

1: The future to me is, like I live today, and if I live today I know it's going to be pretty much like tomorrow. The future to me only comes one day at a time. You got to live one day at a time. You're not guaranteed a tomorrow. I thought I had a future when I jumped. I thought my rating is GS 6, I got a good job, a potential to be an 8 or 9. I had money in the bank and a little house. I finally found what I needed things was going real good then bang someone knocked the ladder right out from under me. Things was going too good and you got to beware. You're not guaranteed a tomorrow. If you live today to your best potential, you'll live tomorrow the same way.

2: A lot of people don't feel that way though.

C: How do you feel (2)?

2: That's it. We're forced to apply ourselves in some direction and try to move in that direction one day at a time.

C: How do you go in this direction?

2: One step at a time.

C: Are you kind of following what other people tell you you can do?

2: No, people told me I wasn't going to live, I wasn't going to sit in a wheelchair, I was never going to finish school. I don't listen to what people tell me I'm going to do. I listen to them tell me what I'm not going to do and then I go out and do it. That's the best way.

- 1: (2)'s had a hard time. At one time (2) was just down and out! He had just nothing to look forward to and he just didn't look forward to nothing. He couldn't feed himself. He couldn't do nothing, but then finally after he got a few little things he could do well then after he got going well it just come into bigger and bigger things. (2: Just that was 1). It just started a chain reaction like an atom breaking up. Now since (2) got that wheelchair, he's a lot happier I think.
- 2: You know what some guy told me the other day. He says you look like a king when you come around in that thing. I said maybe I am.
- 1: You got to play a role.
- C: Do you think you play the role of a handicapped person?
- 1: I try not to. You know what I think--I look at some of these people who can walk, jump, dance and sing, I always use that expression because it's the best way to put it for me, I look at them people and shake my head and say I'm not handicapped, I'm not screwed up, they are.
- 2: I don't either (1). There are a lot of people walking around that I wouldn't want to change places with.
- 1: That's right. The pride that some people don't have. I have pride.
- C: How do you go about building up this pride? There are a lot of things that are telling you you are less than equal to this other person because you can't walk down the street or on the grass. How do you build yourself up to be able to say, I am as good as you?
- 2: It's the people who care, people who know you're worth something, although most people don't. They give you the stamina. You feel that you're not completely worthless because these people do care. You rebel against the other people and say blank you buddy. I am worth something and I'm going to prove it.
- C: And then go out and do the things they say you can't do?
- 2: Right! It's all part of your superego.
- C: How do you build up your view of yourself?
- 2: You don't sit down and say well I'm going to do this and this and this in the next three months and that way I'll feel that much better about my self concept. You just have to fight back or else you're nowhere. You have to care what other people think about you and you have to have someone who cares to give you a little bit of positive reinforcement. It takes other people to instill it don't you think.
- C: So it all started out with other people telling you you were worth it until you saw it for yourself?

2: I don't know if it did or not. When I was in the hospital and they expected me to die, I was not even conscious of people telling me you're going to make it. I wasn't even aware of it, but I did. I don't know what started it there. There was something in my socialization process that had instilled this in me before!

C: That somebody cared?

2: That it was worth fighting for.

1: (2) had a lot of friends too that came over and helped him out and they gave him out.

2: Of course you know two of my friends stuck around after I got hurt, and that was you and ____.

C: What did you do to help him out (1)?

1: Really nothing.

2: He stayed my friend, he still talked to me.

C: While other people dropped you?

2: Well yeah. They brought me around. I don't blame them, but that's the way it was and it hurt me. It isn't because they hated me, but it hurt them to see me in this position. But that doesn't help you though.

C: How did you help him (1)?

1: Well really (2) has helped me more than I helped him. Well when (2) was at St. Pats I went up to his room, and he was awake I think, but I thought to myself if I ever get this way I don't know what I'd ever do. But (2) has been sort of an example for me to follow. I watched his progress through the years and then when zap I got it then I just thought well (2) did it, why can't I. Just like (2), he can do so much in his wheelchair. He even went to some parties with us. But there were social barriers and to get them down. (2: They're there aren't they) They are (2: But what you have to do is drive right over the top. They'll kill you.)

C: What kind of barriers are in your way?

1: Like the Junior Proms, just to sit and watch. That hurts.

2: You bet it hurts.

1: Even though you didn't raise hell, you didn't want to dance.

2: You just had to sit and watch everybody else do it.

1: I don't like to watch sports anymore because I can't participate.

2: Right. Both of us used to love sports, but it's kind of painful.

C: What have you changed your interests towards?

1: Washing dishes, mopping floors. (2) and I come from a mentally deprived area. I think maybe fifteen of our class went to college. That's about all. That gives (2) and I a source of pride.

2: Sure I go down to _____ club to get drunk with the boys and I look around and half of them haven't finished school. High school.

C: So this is one way to build yourself up.

2: You're damn right. (1: Just be better than the other guy mentally). Sure that's something. But nobody else appreciates it though and that's the part that gets you down.

C: Double life?

2: Oh I daydream alot.

C: Why do you do it.

2: It's an escape from their limitations.

1: Because of social pressures.

2: It's like watching an old-time movie in your head when the good guy wins.

C: It's a way of putting yourself on top?

2: It's a way of escaping the parts of reality you don't like.

C: How do you fight these feelings of inferiority that keep popping up?

1: You learn to laugh (2: Right) 'cause you know sometimes people can be cruel and you've got to laugh now because you can't just go punch them in the nose. If they ever punched you back they'd kill you. (2: Right.) I laugh alot outside and then sometimes I wonder why I'm laughing and it hurts. Sometimes when I laugh the hardest it's because it hurts.

2: You either laugh or you cry, (1).

1: There is no use crying over life is there, (2)? If we had a choice. We didn't have a choice about our accident. It's just one of those

things you never have a choice. For ever right there is a wrong, but you really don't have a choice. You make a choice if it fits your conscience, but otherwise you don't have a choice. Because how the hell do we know if it's wrong or right.

2: I'm a fatalist. You try all you can but there is still something else that is steering you along, and you either make it or you don't. But you've got to try no matter what it is.

- C: What's your definition of a fatalist? Do you expect the worst and be glad if something good happens?
- 2: Well no, upstairs there is a big book with your whole life written down in it and there are options, different trails you can take, and they're all written out. You try the best you can. You go down one trail, but it's still written in the book. I'm an optimist and an idealist in my heart, but I still think . . .
- C: This was planned.
- 2: Right. It's all a big plot.
- 1: Things happen for a reason.
- C: If you look too far ahead are you more apt to fail?
- 1: If I look too far ahead, it gets scary. (2: You get scared, right.) Because the way the world is today I can live in it, but the way it might be tomorrow I just might not be able to.
- C: Because this way you can plan because you know what's ahead, but if you try to plan for two weeks ahead you don't know if something's going to radically change and that you won't be able to cope with it.
- 1: We can't take these radical changes like you can.
- C: You have a limited ability to change physically.
- 1: I went to San Francisco this summer and I suppose Montana is about twenty years behind culturally--cultural lag--but I could not survive in San Francisco. I could not make it across the street. The pace is too fast. I couldn't walk up and down the streets of Chinatown because the streets were too steep. I couldn't grab onto a cablecar. It scared the hell out of me. I didn't want to part of that town [sic]. There are little things we become aware of. You almost become paranoid. (2: Right.)
- C: Everyones out to get you?
- 1: No.
- 2: There is a certain amount of fear involved in everything because the little everyday things that everyone else takes for granted are a hump.
- 1: Everytime I go up a step.
- 2: Sure. Are you going to fall on your face?
- 1: Our odds are a hell of alot greater.
- C: The chances of something happening wrong are greater for you.

- 2: In the back of our minds . . the chances are very slim that someone is going to jump in a lake and break their neck. The chances are very slim that somebody is going to fall under the fender of a car that's going to roll on his head. But this has already happened to us so we know that these wild odds do exist. This is kind of in the back of your mind. This happened once, what else can happen. We're alot more aware of this than other people I think.
- C: So you take alot more into account than most people do? Hypersensitive."

APPENDIX B

The following is an initial interview held with a male respondent:

Again his name is omitted to protect his identity.

C: "Can you tell me about your accident?

I: I got hurt in an automobile accident in 1965. I pulled the vertebrae between T5 and T6 apart. I didn't break them, just pulled them apart enough to break the cord then they went back together. That paralyzed me below T5, T6 which is midchest down. That's about it.

C: Were you driving alone?

I: Yeah.

C: This was in California wasn't it?

I: Yeah. It was outside of Palo Alto.

C: The main thing I wanted to talk to you about was Phylis said you had trouble up in Whitefish. People had difficulty accepting you.

C: Well this is a typical reaction wherever you go. I don't think Whitefish is any different.

C: Can you describe their reaction then?

I: There are probably three reactions. The first is disbelief. What are you doing out? You ought to be in your little room in the hospital. You are not supposed to be out. The second reaction is anything I can do for you friend, let me help you, can I hold the door, this over-sympathy thing. The third reaction is the over the shoulder type look reaction. They try to ignore you but can't quite do it. They don't say anything or do anything. They just look. These are probably the three typical reactions you get. In Whitefish, working in the school there, after the first three weeks eighty percent of the people accepted the fact that I could do just about everything in a wheelchair. Twenty percent never did accept the fact. These are professional teachers. They could never accept the fact that I could do anything.

C: How did they treat you?

I: They didn't. They ignored me. They would avoid any contact. They wouldn't exclude me. They would not initiate any contact. If I were to initiate the contact then they would continue up, but they were always glad to get away. I think they were just uncomfortable because they didn't know how to handle the situation. The other ones, finally the chair wasn't there any more and they treated me just like a regular guy. As far as the kids go, if you are interested in that, I had a better reaction in California than I did here in Montana.

C: Did you teach in California?

I: Yes, and very successfully.

C: What was the difference between the two?

I: Well, my attitude I suppose. Now you're talking of divergent social economic backgrounds. In California the school I was in was primarily an upper middle class to upper class. Whitefish is lower lower to welfare with very few middle class. Whitefish is really poverty. In California their reaction was unity. It brought them really together. They had something in common and my reaction was that I let them help me. The school was laid out in a huge complex and I let them push me. It was the biggest treat of the day if they could push Mr. _____ down the hall. They would have to take turns so everybody got a chance. It was a big thing.

C: Even though you can push yourself?

I: Oh yeah, right. At times I would have to tell them don't push me, let me push myself. I need the exercise. And they were hurt because they wanted to help. They were genuinely concerned but they also knew I could do it. The first week the kids in California didn't know what to do. I don't think they had ever really seen a person in a wheelchair before or even talked to one. After the week was over they could see that I could write on the board, play basketball, and I could spank a few if I had to and after that . . .

C: They settled down as soon as they felt you out and found what you could do and what you couldn't?

I: Yeah just like anybody else, but the chair itself I think brought us together. They were proud of the fact that they were in Mr. _____ class. A good example of this is we were bussed over to another school for a concert, and I couldn't get on the bus so I drove my car over and met the kids there. Well, they weren't going to leave the side of the bus until I got there so they could make sure that I got in all right. Well this is a switch. These are fourth grade kids. They are going to take care of me and make sure I got there not the other way around.

C: It kind of reverses the student-teacher role?

I: It sure does. Go to Whitefish now, there because we didn't have the halls, everything was inside, I didn't let the kids push. I just wanted to try it and see what the reaction would be for myself as well as the kids. But I found the kids in Whitefish, now maybe I am making value judgements I suppose maybe it's because of their background, they didn't want to get as close. They were standoffish. They didn't reject the chair. It didn't bother them. It fascinated them more than anything. Probably that was the big thing as opposed to the kids in California. There they accepted it and it was a part of life. They ignored it and forgot it was there after awhile.

C: Do you think that they had more contact with it in California?

- I: No, well that might be true. The Mayor of San Clemente where we taught was in a wheelchair. He was a paraplegic and the kids knew Dr. . This might have made a difference. They've seen him on television in his wheelchair, and he used to ride around town in a little white golf cart and stop and talk to the kids. The kids in Whitefish I don't think ever, they might have seen like on Ironsides a guy in a wheelchair. It was more like fascination. They were more concerned with how do you turn it, how do you stop it, what makes it go, but they didn't reject it. The chair didn't bother them I don't think except the first couple of three weeks. The kids in California were more mature and more self-assured. They had been allowed to do more things and had been exposed to more things. The kids in Whitefish were immature. They had less contact with the outside world. They were more selfish with their emotions. In California to show your friendship in a friendly way was acceptable. In Whitefish you didn't do that. If you wanted to show any kind of a friendship it had to be in a hostile way. If he was a friend, you hit him.
- C: That could be the lower class--physical instead of verbal.
- I: That's why I think the fascination with the chair. They couldn't really understand how I could get around in a wheelchair, and why I would want to. Maybe they weren't mature enough to realize that these things do happen.
- C: Why did you decide not to stay up in Whitefish? Did it have to do with the reaction of the people?
- I: No. Four reasons I suppose. First is the snow. It's a small town, the streets aren't paved, aren't plowed. It's too hard for me to get around. Second, we didn't like the community for economic reasons. It's clickish. It's just not a nice place to live.
- C: I suppose they are very ingroupish? You have to be a native Whitefisher or native Montanan or you are out--and Whitefisher comes first.
- I: Right, a Whitefisher in the right business and live in the right area with the right number of acres and cattle. It's very clickish. The third reason we left was my G.I. Bill was running out so I thought I had better get back and get my Masters. As far as the acceptance of the people there was no problem at all.
- C: How did the townspeople take to you that didn't have contact with you at school?
- I: The businessmen had no negative reaction at all.
- C: They probably kept it on a business level anyway so it was easy for them to keep it strictly on this level?
- I: Definitely. I found nobody outside of my profession who was willing to get involved.
- C: Afraid?

- I: Yeah, I think it's this old error of dependency. This thing that stopped any kind of involvement would be the fear of ending up being a crutch for someone in a wheelchair. You always have to do things for them. This is the false idea people have of people in a wheelchair.
- C: They are afraid they can't back out once they are involved?
- I: Right. The myth of people in wheelchairs are that they are helpless, completely dependent, and once you become friends you can never lose them because they are just constantly bugging you for help. But I didn't have any negative reaction at all. The only negative reaction I got was because I had long hair and sideburns. They were most helpful when it came time to get into their shops. This is stuff that I got second hand, but this type of stuff never does come first hand. Some of the people that weren't working up there were grumbling about the fact that why should I be working when they are not and are able bodied.
- C: That's typical lower class--anyone who is competing against them for the job. That is why a lot of the lower class white despise the Negroes. They are competing for the same jobs. They have more prejudice than middle class or upper class whites because they are in direct competition. Let's get back to your accident and rehabilitation. How long were you in the hospital after you were hurt?
- I: About six months.
- C: Then did you go out to Phyllis?
- I: I started in California. They wouldn't let me do anything until the bones in my face healed. I had a hole in my lung. I had a little rock. In fact, I think I am the only one in the U.S. who ever had a rock in their lung and then coughed it up. My face was all smashed up and I had it in a harness like deal. After I got that stuff all taken care of, got rid of the pneumonia and off the drugs, I got hooked on barbituates and morphine, I started some physical therapy. Just mainly sitting up. I couldn't sit up without getting dizzy. You know getting the heart used to it. The big thing was waste removal. I lost control of that. I went down to therapy at Connor and just rolled on the floor to get the feel of things. Then we tried to stand on the braces. It wasn't therapy really, but mainly orientation. That was about Christmastime and it looked pretty hopeless down there as far as I was concerned. I just wasn't getting anywhere, and I didn't know anyone. My family was up here so my uncle loaded me in the back end of his camper, and we came up through a blizzard and hit a deer on the way, and I was scared of riding in cars then. I was riding backwards in the back of the camper and sliding all over the place, and I thought oh my God I am going to die again for sure. Then we got to Oregon and hit the deer, and I thought of God I've had it, forget it. We got here Christmas Eve and I stopped home a week or so and then I went to Community Hospital. I was there a day or so when I indicated that I wanted physical therapy, and I would like to go back to school. Well Phyllis got a hold of me and Jesus she worked me six to eight hours a day so I couldn't move. It was the greatest thing in the world because you don't have time to think about it. Phyllis is the key to my whole success so far. She got me some money through Social Security so I could live

a little bit and got me in school. I was hardly able to sit up and these guys were wheeling me into school. Phyllis built up my arms and legs so I could stand a days work.

C: Can you tell me something about your change in mental attitude as you went through this thing? I know you were married before this and your wife left you after the accident. Can you tell me how your attitude changed throughout this ordeal? I'm sure it must have seemed like the whole world was against you after this happened.

I: Well no it didn't. Sometimes I wonder if I'm not a little weird because I think this way, but when I first gained consciousness the doctor came in and said (I) you are paralyzed. I said I know and it didn't bother me. You know shock and all that and it still didn't bother me when I came through to this thing. I accepted it as part of everyday. Maybe I forgot the part where I had to rationalize it like come on fella OK you're here, you're in it now take care of it. I might have erased it. When my first wife left it didn't bother me much because I sort of expected it. Laying there you kind of think it's unfair to her to have to stick around through something like this. So when it was decided it was fine. It really didn't bother me. I guess you could say I wasn't really in love with her.

C: Were her reasons that it was just too hard to face?

I: Mental cruelty was the deal.

C: This is it. She couldn't face life with you in a wheelchair.

I: That's right. That didn't bother me too much. The fact that I was paralyzed didn't bother me too much. Again it was probably the shock and being on the drugs, by the time I came out of the shock and the drugs which was about six months later I had a lot of time to think about it.

C: What was going through your mind at that time?

I: Not much.

C: What worried you about this? Something must have I'm sure.

I: No.

C: Did you worry about your future?

I: No.

C: Did you have any training beforehand that you knew you could fall back on?

I: Yeah. I was an electronics technician. I always knew I could do that. I think I had enough confidence in myself, maybe this is the whole thing. I had enough self-confidence that I figured I could do something. I could take care of myself somehow. I was never really afraid of not being able to do something. The thing that probably worried me, and this is later after I started going to school, was if I could do what I wanted because this limits you quite a bit.

C: Did you go through stages?

I: Ups and downs?

C: Yeah to build up your mental attitude? You didn't have any deep depressions did you?

I: No, I didn't go into those battling things or those long minutes of depression.

C: In talking to the other people, they seemed to go through a stage where suddenly the world is cut out from under them, they have no future, no self-confidence, kind of a worthlessness feeling.

I: No, I am giving myself away here. I think before I got into the accident, I was a very ego-centric person. There wasn't anything I could try that I couldn't do any most of it I did well if I wanted to do it. I think this still hung on when I was in the hospital. I wasn't worried about it, I figured that if I wanted to do it, I could do it as long as I chose the right thing. I was damned sure I couldn't be a automobile race driver, but I could be the draftsman or the engineer and even if I wanted to be the mechanic and I knew that and I had enough confidence in myself. So I wasn't really lost. The world wasn't really gone. For awhile there I didn't think I would be able to get out of the hospital bed, but that didn't bother me either because I knew I still had my mind. I could write if I had to. I could do art things. There is always something to do so I wasn't worried about that at all. It was kind of a challenge. Being paralyzed was something new, it was a challenge there.

C: Is this how you make life exciting and worth living?

I: I think so. I had a doctor tell me I wasn't going to get out of bed and I told him you bastard you're lying to me because I'm going to get up. Probably that's the big thing, tell me I can't do it and that's the first thing I'll try. And a lot of people tell me I can't drive a car well that's elementary. The challenge is the biggest part of the whole thing. To be able to say yeah I can work and it's fun to look a guy in the eye and say a yeah last year I got my deer did you get yours? I know damn well they didn't get it and I watch their reaction. That's probably the biggest thing to be able to do something and knowing that people expect you not to be able to do anything and then to pull this thing off. Maybe it's competitiveness.

C: This is what makes you feel better--to feel one-up on them. You can do it and you want to show them you can?

I: Yeah. I don't particularly care if they know it as long as I do.

C: Keeps your self-respect.

I: Yeah. Part of my big hangup for a while was can I be a man and then I met my wife at school and I did a thorough job of hustling her.

C: So you proved it.

- I: Yeah. The whole thing worked out pretty good from all ends of it. I was able to get a job. This is kind of a climax, but it's not a climax because I'm not satisfied at all with what I am.
- C: When you say you're not satisfied do you mean with your job with teaching? You want to get on the administrative end?
- I: I've got somewhere to go and I don't know where. Right now it's not big enough. It's not fast enough. It's not powerful enough.
- C: Do you eventually want to be a principal?
- I: A yeah, that's the next step, but I want to go higher than that. The only thing that's going to hurt me is not my ability, but it will be peoples' ability to accept me for what I am.
- C: You have to sell yourself and do a better job than the ordinary person would have to do to overcome this.
- I: Yeah, and good example of how hard it is--when you go into a room for an interview a person in a wheelchair is always the last person to be interviewed. Usually because he is the last person seen. He is down sitting low. You are the last person interviewed--then when you get in there damn they are so sick of listening to people. Then the guy's own pride is there too. Usually you are interviewing for his job or something close to it and they look at you and say God, you can't do my job. How can anybody in a wheelchair do what I can just barely do. This inferiority thing. People in wheelchairs just aren't supposed to be able to do anything. When you go to compete for their job, it makes them look bad in their eyes. I don't like the way people in wheelchairs are being treated today. I don't like the way they are discriminated against.
- C: In a sense you are an ethnic group, a minority within yourself and you are being treated like the other minorities.
- I: Even worse. You are treated with infant apathy and pity and that's worse.
- C: Do they think you are mentally disabled as well as physically?
- I: Oh God yes. Sometimes they look at you and smile like oh if only you could speak, and you want to reach up and clout them right in the mouth. With those people you get verbally very irrate, and I'm sure that at times if I could reach up and hit them I would do it.
- C: So you react verbally instead of physically? This is a skill you have developed?
- I: Yeah, you develop the skill and sometimes they don't ever know it. I feel sorry for someone who is in a wheelchair and has low mentality or hasn't developed his skills yet because then he's lost, he really is. It's hard enough to sell yourself in the everyday world when you haven't got a handicap. You have to be good, but you have to be even better when you're in a wheelchair or have any other physical handicap that's readily identified. I think I know what a Negro feels like when he is

truly discriminated against. I think I do. It's rather frustrating to go downtown to mail a letter and the building is there, but not to be able to go inside.

C: In but not of society.

I: Yeah, it's like having a huge corrugated metal fence that you can see through. You can't get over it or around it, but you can sit on the outside and watch what is going on inside. Every once in a while somebody comes over and pokes a little cotton candy through the fence. It bugs me and it bugs a lot of us I guess.

C: What would be the cotton candy to you?

I: Just being able to have a job. The biggest thing the physically handicapped want is independence. I want to be able to do things by myself for myself. Being handicapped like I am it means I have to have money. I can't build my own house. I have to hire someone to do it. I can't fix my own car. I have to hire someone to do it. But I can draw up the plans to my own house.

C: How do you rationalize this dependence to yourself? You said that with the kids you made it a game whereby you were doing them a favor by letting them help you. Is this the way you rationalize it?

I: In a way I do. Sometimes I simply use people because they are there. Sometimes when I'm in a store there might be a four inch step that I can easily hop my wheelchair over, but there is a guy walking next to me and he's perceptive enough to know that he thinks I can't get over that so he says can I help you. Well, maybe I'm tired that day and so I say yeah. The reason I say yeah is that it'll make him feel good to be able to help me not that I really need it. So that's one way I do it. The other way was if I'm downtown and I want to get out of my car and onto the sidewalk without going all the way around the block to a driveway somewhere I might just say hey come here, help me up on the curb. Then I rationalize and say--well buddy God damn it you didn't think about this when you had them put the curb in. I pay the same taxes you do so now you can pay for it. You get dirty about it. Usually people in wheelchairs don't do anything they can't do. I go downtown to certain areas because I know I can get around there. Sometimes I stray off and if I do and I get in trouble--if you do get in trouble you're prepared for it. If you do need help it's a necessity. If it happens you let someone help you because it makes them feel good and sometimes you get help because you just have to have it. I used to go down to the Monks Cave. Now I had to have help to get down there and get a beer. There it was just a matter of I was with friends and those people were helping a friend get down to a good time and that's all there was to it. I think I like to avoid help as much as I can. You get annoyed at over help. Things you can do and someone continually wants to do them for you is in a way degrading.

C: It's pity. That's what you don't want--charity or pity?

I: Yeah, help.

C: But that's different.

I: Right.

C: You can sense that. You've had so much that you know when it's genuine and when it's pity.

I: Right. But I find as far as the help and the acceptance, the people I knew before are the people least apt to accept the fact that I'm in a wheelchair.

C: Why is this?

I: I think it's because they knew me before.

C: They refused to accept it?

I: Maybe they do. Maybe that's it. The people I just meet accept everything you do. They have nothing to look back to. I guess this is it. They can't regress and say well he used to be able to . . . Like the fellows I hunt and fish with, these guys didn't know me before and they are continually amazed at what I can do. They won't rush over like if we are hunting and well like when I shot my deer. I'm kind of proud of that. I'm one of the few guys that have been able to do that. I shot it. They came over and the deer was over in the woods probably another fifty yards from me and they didn't immediately go rushing over and drag it out for me. They asked--do you want us to go get it for you? If I thought I could have made it I would have said no I'll get it myself, but I couldn't so they say--yeah you lucky shit, shoot it then make us do your dirty work for you. It's that kind of a relationship that you appreciate.

C: They take you as you are now and probably it would be difficult for someone who knew you before to accept your incapacities now.

I: I think that in many cases the people who have known me before then meet me say for a few weeks, they are frightened I think by what's happened and partially by what could happen to them and partially by ignorance.

C: Do you think they remember the good times before and think you are incapable of having them now it could never be so good?

I: No I don't think so. After a couple of years some of these people have come around to this final acceptance but these have been the younger people. Maybe because they are more flexible. They've come around to the point that they forget even that I'm in a wheelchair. Which is nice. You might think well how can that be nice, but you see when people look at you and there isn't a wheelchair there, they have accepted you as a person. Say they call up - come on let's go, well get all ready to go and get there and they say oh shit, I forgot, and it's some horrendous thing we've got to do. You think wow what an ass how could you possibly forget that that's a fifty foot cliff. I'm in a wheelchair and we have to get up it. But it does happen. Then we go through it together of how to get up there and that ends up being more fun than anything. The whole key is the acceptance by myself and the other

people involved. If anybody is the least bit leary it inhibits them, they change their attitudes.

C: Do you have a routine to your life? Do you have to stick to a pretty rigid routine?

I: No, God no. Well before you go anywhere, like if I were going to leave the house right now and go downtown, first I'd call before I go anywhere to be sure they have what I want. Then I think things through. It's hard to go to an unfamiliar place. You have to plan ahead. You are afraid of having no control over the situation."